Mental Health and Asian women: A qualitative study of women's experiences

By

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A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology

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May 2005

Contents

Appendix 18 Notes to contributors: Feminism and Psychology
(Reflective Paper)

List of Tables

List of Figures

Dedication

In loving memory of my friend Shabina Begum. Your love and support was with me all the way throughout this thesis.

Acknowledgments

I would like to take this opportunity to thank the women who participated in this study; without you this thesis would not have existed. I am extremely grateful to all the women for sharing their personal experiences with me. I was privileged to have your time and honesty.

Thank you to all the managers and staff at the beauty salons for your kindness and support with the recruiting of participants. A special thanks for the room space, which was invaluable.

I would like to thank Dr Helen Liebling for her support and guidance, especially with the Literature review. Thanks to David Giles for all his support and dedication over the qualitative analysis of the Empirical papers. Thanks to Dr Haseena Lockhart for her feedback on the final drafts and her immense support towards the final stages.

A special thank you to Jill Simpson for her calming presence during particular stressful times and for the question "How's you in all this?" Thank you to Dr Helen Brittain for her immense support and guidance over a stressful ethics submission.

A thank you to all my wonderful peers; Tom, Vicky, Nicky, Ailsa and Helena for their kind support. Thanks to Milly and Rich for the brownies and cups of teas. A special thank you to my dear friend and peer Lisa Hewitt; your support was immense and I will remember it always. Gratitude to your phrase "We will get it done" and we did.

Finally my indefinable gratitude goes to my family for their relentless encouragement and a love that goes way above the call of duty. I would particularly like to acknowledge my parents for supporting my decision to undertake this training. I know that it has been a challenging time, and one which goes way beyond what was expected of me. I hope that this work proves to be a powerful influence on other Asian women and inspires them to push the boundaries, and step forward.

Declaration

This thesis was carried out under the supervision of Dr Helen Liebling, David Giles and Dr Haseena Lockhart. The ideas of the study and design were collaborated with my supervisors. Ethical approval was obtained from Warwickshire Local Research Ethics Committee (see Appendix 1). I organised access to all the participants and conducted all the interviews. My supervisors and a peer qualitative research group collectively checked the validity of my analysis and my reflectivity during the research process. My supervisors checked drafts of my thesis chapters. Apart from these collaborations this thesis is my own work.

The literature review paper (Chapter 1) is being prepared for submission to the Psychology of Women Section Review (Thabusom., Liebling., & Lockhart, 2005). The first empirical paper (Chapter 2) is being prepared for submission to the Journal of Community and Applied Social Psychology (Thabusom., Giles., Liebling., & Lockhart, 2005). The second empirical paper (Chapter 3) is being prepared for submission to the Journal of Community and Applied Social Psychology (Thabusom., Liebling., Giles., & Lockhart, 2005). This thesis has not been submitted for a degree to any other university.

Summary

Asian women and mental health has largely been a neglected area of research. International and national research on self-harm and suicide suggests that South Asian women are at an increased risk. Mental Health services acknowledge their lack of involvement with this population group and have instigated initiatives to increase South Asian women's contact with their services. One such initiative is to carry out further research with South Asian women to help understand their distress and examine implications for Mental Health services.

The first paper in this thesis reviews the relevant literature that explores reasons for self-harm and attempted suicide in British South Asian women. The Literature review provides a methodological critique and implications for further research in this field. The second paper in this thesis is an empirical paper which adopts a grounded theory approach, exploring mental health issues in a non-clinical sample of British South Asian women. The third paper is also an empirical paper which adopts a phenomenological approach in order to explore a unique British South Asian woman's experience of self-harm and attempted suicide. The final paper is a reflective paper which explores my research journey.

Chapter I: Literature Review

Exploring reasons for Suicide and Self Harm in South Asian women: an evaluation of selected literature

Word count: 5995 (Including References)

Submission to: Psychology of Women Section Review

1.1 Abstract

Previous research has found high rates of suicide and self harm in Asian women. Initially this paper aimed to provide a suitable definition of self harm and suicide incorporating a discussion of the complexities involved in defining these concepts. This paper then aimed to explore literature on the explanations for why Asian women self harm and attempt suicide. Explanations such as violence against women, culture and identity issues and racism are explored. In addition the medicalisation of Asian women's distress is discussed. The methodology of the research in this area is explored and it is evident that much of the research has focused on collecting general themes and a lack of in-depth individual analysis and theoretical explanations have not been explored. It is suggested that further research in the area of Asian women and self harm and suicide needs emphasis on the clarity of methodology of studies in order to offer a greater understanding. There is little research which offers in-depth discussion on the reasons for suicide and self harm in Asian women and this paper concludes that more detailed qualitative research would be a useful contribution.

1.2 Introduction

The aim of this paper is to evaluate selected literature on the explanations of suicide and self harm in South Asian women. Firstly, definitions of suicide and self harm are discussed. A significant section of this paper then aims to review the literature, summarising selected published empirical papers that focus on the explanations of suicide and self harm in South Asian women. Finally, findings are considered for the potential applications of how future research may best proceed to promote our understanding of the structure, process and potential clinical application of working with Asian women who are at high risk of suicide and self harm.

The following strategies were used to establish the literature included in this review. Firstly major databases were searched for peer reviewed published literature, excluding dissertations, during December 2004. This included, PsycINFO, Medline (Ovid), BIDS and Web of Science. The specific search terms utilised were Asian women, suicide, self harm, ethnicity, mental health, causes and explanations. General searches were also carried out for terms; attempted, assisted, committed suicide, self injury and minority groups.

The search results for these general terms were screened for their relevance to this particular review. Following this, the identified sources were checked for references to other publications containing any of the search terms. These publications were then collated and this process repeated until no new references were obtained in February 2005.

Throughout this process the aim was to select papers where the substantial focus was explanations of suicide and self harm particularly in Asian women. These strategies collectively identified five empirical studies; illustrated in Table 1. A further seven studies about suicide and self harm in Asian women were also reviewed (see Table 2). These latter studies were included as there was relevant discussion on the reasons for Asian women's self harm and suicide but the substantial focus of these papers was about professional's responses to Asian women and service implication.

The term South Asian refers to individuals whose ethnicity originates from countries of the Indian subcontinent: India, Pakistan, Bangladesh, Sri Lanka, Bhutan and Nepal. In this paper a substantial amount of the articles are aimed at reviewing the perceived causes of suicide and self harm in South Asian women born in the United Kingdom.

Table 1. Summary of Studies investigating Suicide and or Self-harm and identifying causes.

(South Asian Women – SAW)
(History of Attempted Suicide- HoAS)

AUTHORS	FOCUS	SAMPLE	SOURCE	DATA COLLECTION	ANALYSIS	PERCIEVED CAUSES
1.Hicks & Bhugra 2003	Perceived causes of suicide attempts by U.K south Asian women	180 SAW	54% of sample from GP clinics, and 46% were from community organisations	Initially Focus Groups Then Questionnaire	Thematic analysis – focus groups Intercooled stata 5.0 software- questionnaire	Violence by husband Trapped in an unhappy family situation Depression
2.Chew-Graham, Bashir, Chantler, Burman & Batsleer 2002	south Asian women – Psychological distress and self harm	40 SAW	Women's groups in the HAZ area (Manchester, Salford & Trafford Health Action Zone)	Four Focus groups using Interview Guide	Framework Analysis – deriving themes	Systemic issues – social, political & economic; domestic violence; poverty; language problems; family &children issues & health. Underlining some of these were; racism, stereotyping, religion, concept of honour in family (izzat)
3.Bhardwarj 2001	Reporting on self harm and suicide and what are the reasons	4 SAW	Newham Asian Women's Project	Individual interviews with Asian women with history of attempted suicide Focus groups with young Asian women	Quotes used to represent answers – Qualitative	Parental, Family & community oppressions. Violence and abuse. External factors – racism, wider male domination, media.

4.Bhugra, Baldwin, Desai & Jacob 1999	Looking at culture and attempted suicide	1st Group:27 SAW – HoAS 27 SAW Control Group 2nd Group:46 White women-HoAS 29 SAW-HoAS	GP surgery and other medical services	Interviews – also included GHQ (Goldberg 1972), CIS-R (Goldberg 1972), LEI (Cochrane& Robertson 1973) & Cultural Identity Schedule (Bhugra et al 1999)	Two inter-group comparisons	1st Group: SAW with HoAS, more likely to have history of suicidal behaviour & unemployed. Parents would have arrived in UK at an older age. More likely to have inter-racial relationships & changed religions. 2nd Group: White women with HoAS more likely to have mental illness. SAW more likely to have relationship issues
5.Bhugra 2002	Suicidal behaviour in SAW in UK	26 SAW with HoAS 26 SAW attending GP surgery Equivalent number of White women with HoAS	Women presenting at Accident & Emergency, Psychiatric & Medical Wards. GP surgeries	Semi- Structured interview using Cultural Identity Schedule (Bhugra et al 1999), Life Events (Cochrane & Robertson, 1972; Lewis et al, 1992), GHQ-28 (Goldberg, 1972) & Clinical Interview Schedule-R	Group comparisons from interview scores	Culture conflict contributing to a sense of helplessness and hopelessness.

Table 2: Studies on Suicide and Self-harm
(South Asian Women – SAW)

AUTHOR	FOCUS	PERCIEVED CAUSES
6.Chantler, Burman & Batsleer 2003	SAW: Exploring systemic service inequalities around attempted suicide and self-harm	Sexual & Physical abuse, Domestic Violence, Immigration issues, Forced marriages, Racism, Issues of loss. Also poverty & homelessness – these intensified in SAW by the intersection between domestic/familial contexts & state/structural oppression.
7. Prosser 1996	Suicides by burning in England &Wales	Marital break up/problems, redundancy/bankruptcy, bereavement & evictions.
8. Thompson & Bhugra 2000	Rates of deliberate self-harm in Asians: findings & models	Culture conflict, sexual or physical abuse & stress in family or school in younger Asian women. Older Asian women; arranged marriage, having liberal attitudes & less religious beliefs.
9. Merrill & Owens 1986	Ethnic differences in self poisoning: A comparison of Asian and White Groups	Asian women less likely to have psychiatric history, or suffer from personality disorder. Culture conflict seen as most common among Asian women.
10. Burr 2002	Cultural stereotypes of women from South Asian communities: mental health care professionals explanations for patterns of suicide and depression	Racism, Culture conflict, Subordination & isolation, Arranged marriages.
11. Chantler, Burman, Batsleer & Bashir 2001	Attempted suicide & self-harm SAW	Sexual/physical abuse, Domestic violence, forced marriages & immigration.
12. Bhugra & Desai 2002	Attempted suicide in SAW	UK born SAW; Gender-role expectations, alienation from culture (own & wider), family conflict, domestic violence, cultural conflict & poor self esteem.

1.3 Background

The Medical Chief Officer's Working Group on health variations highlighted the importance of improving the health of high risk population groups in achieving government targets and the need for further research on these populations. The National Service Framework paper *our healthier nation* outlines targets for reducing the national suicide rate by at least one fifth by 2010.

Although suicide rates are falling, there are more than 4,700 suicide's in a year in England and Wales (Samaritan, 2004). Many more suicide attempts are made each year and at least one person in every hundred appearing in hospital, after a suicide attempt, will succeed within a year, and up to five per cent do so in the following decade (Hawton and Fagg, 1998). The suicide rate amongst young Asian women is twice the national average (Soni-Raleigh, 1996). Soni-Raleigh, an epidemiologist, at Surrey University and the leading expert in Asian studies, stated that 1,979 women of all ages killed themselves from 1988 to 1992 in England and Wales. Of these suicides, eighty five were Asian women; nearly double their proportion in the population. These findings are further supported by other empirical papers such as Merrill & Owen (1986) and Patal & Gaw (1996) who have indicated that the risks of self harm and suicide attempts, as well as completed suicide, are high in UK born South Asian women. This data is also consistent with international literature (see Flisher & Parry, 1994). Disproportionately high rates of attempted suicide have been found in ethnic South Asian women living in regions of India (Banerjee et al., 1990; Shukla et al., 1990) in Pakistan (Kahn & Reza, 2000) in Sri

Lanka (Miller & Kearney, 1988) and the United Kingdom (Soni-Raleigh, 1996). In all these studies rates of suicide and attempted suicide are highest in young South Asian women.

There has been some published literature focusing on the explanations of suicide and self harm in South Asian women. This review provides a summary of a selection of the published empirical literature allowing researchers to quickly and easily compare findings across different studies. From an applied perspective clinicians should be aware of the causal mechanisms that predispose Asian women attempting suicide and self harm.

1.4 The complexities of Defining Suicide and Self Harm

Defining suicide and self harm is problematic, as there is no universal clinical consensus. Many different terms are used; these include self damaging behaviour, attempted suicide, self-poisoning, parasuicide, suicide attempt, self mutilation, self injury, self wounding and deliberate self harm. For the purposes of this paper, the following definition by Fahmy and Jones (1990) has been used. They describe self harm as:

> *Any non-accidental behaviour initiated by the individual, which directly results in physical harm to that individual.* (Fahmy and Jones, 1990)

It is generally accepted by authors who work clinically in this area that there is an important difference between attempted suicide and self harm, and that this difference is fairly clear; in attempted suicide the person usually intends to kill them self, and in self harm the person usually does not. However, in the views of Babiker and Arnold (1997);

> *An excessively simplistic adherence to this distinction is problematic, as it ignores the fact that often what is presented as a suicide attempt, does not in fact involve*

> *an intention to die. The individual may have complex and ambivalent, and also confused, views of their exact intent.* (Babiker and Arnold, 1997)

Kreitman (1977) pointed out that while a clear definition of the difference between attempted suicide and other forms of self harm can be attempted in conceptual terms, the empirical definition is fraught with difficulties. Krietman (1977) argues that whilst it may seem easy to distinguish between self harm and suicide on the basis of lethality and intent, it is more complex to distinguish between repeated acts of self harm and parasuicidal behaviour (Babiker and Arnold, 1997). However, authors have noted that completed suicide is often preceded by escalating episodes of self harm (Dooley, 1990). As Modestin and Kamm (1990) said;

> *It is not possible to differentiate reliably between suicide attempts in the narrow sense (death intended) and parasuicide (death not intended).* (Modestin and Kamm, 1990)

However, both Lester (1972) and Ross and McKay (1979) have emphasised the distinction between self harm and suicidal behaviour. Ross and McKay (1979) stated;

> *There is in the action of the self mutilator seldom intent to die and often very little risk of dying. Although a self mutilator could engender his own death by his behaviour, in the vast majority of cases, this does not happen. His behaviour is actually counter-intentional to suicide rather than suicidal.* (Ross and McKay, 1979)

Morgan (1979) used deliberate self harm to draw a distinction between deliberate non-fatal acts and true suicidal behaviour where death was the intended outcome. In a study by Liebling and Chipchase (1993) they found that women had different, or more than one

intention when self harming and illustrated that it was difficult to separate suicide attempts from self harm. Indeed, Liebling (1992) discusses the possibility of self harming and suicidal behaviours being seen as a continuum.

> *The possibility of a continuum of self destructive behaviour has rarely been raised in the context of prison suicide research. An important oversight in the struggle to treat the behaviours as separate has been the evidence that there are common causes of the two behaviours.* (Liebling, 1992)

Much of the earlier research in this field endeavoured to establish a difference between suicide attempts and self harm. The argument hinged on whether the latter is merely a failed suicide or a distinct act with a different set of meanings in which the primary aim is not self-annihilation. Of the research reviewed, it is widely recognised that self harm is a distinct category from a suicide attempt. However, the term self harm is commonly used interchangeably with parasuicide to cover a broad range of behaviours.

1.5 Explanations for suicide and self harm in Asian women

1.5.1 Violence against women

In a study carried out by Hicks & Bhugra (2003) women were asked to comment, from a compiled list of factors, those that they believed to be causes of suicide attempts in Asian women. Ninety-two per cent of the women agreed that violence by their husband was a causal factor and 40% of these women chose 'strongly agree'. This was the largest proportion to strongly agree with any of the items on the list; thereby highlighting the significance of domestic violence in Asian women. However, it could be argued that the list of possible causes, in this paper, was not comprehensive. There may have been other factors considered important by participants that were not offered in the list. The factors

on the list included; marital problems, violence by the husband, family conflict, being trapped in an unhappy family situation, in-law problems, depression, fear of shame in society, losses in family, abuse by family members and finally problems with children. This list was derived from an earlier study which carried out focus group interviews, to determine the causes of self harm and attempted suicide from which emerging themes were developed. Hence it could be argued, that the focus group increased the validity and social relevance of the factors on the final list of causes.

In a study carried out by Chew-Graham, Bashir, Chantler, Burman & Batsleer (2002) the trauma of domestic violence was also a common theme which was additionally viewed to lead to isolation. This study was based on samples of women who were accessing services for Asian women. There were four existing services that were used for this purpose. These included Saheli, an Asian women's refugee residents group; 42nd Street, a young woman's group; Women Working Together, a community project and the Bangladeshi Women's Project. Hence women may be in contact with services due to their experience of domestic violence. The method by which the data was collected was once again through the use of focus groups. This meant that the main themes were derived from the discussions, one of which was domestic violence. It could be argued that this gave little room for discussion of other themes or voices that were mentioned on fewer occasions. In terms of thinking about the issues raised by the above study, research carried out by Bhardwarj (2001) also argued that the violence and physical abuse towards young Asian women contributed to a community sanctioned method of curbing women's independence. Issues such as sexual abuse and rape were often suggested to be a

precursor to self harm, among those women participants interviewed in the Bhardwarj's (2001) study. Burstow (1992), Pembroke (1994), Arnold (1995) and Liebling et al., (1997) have also recognised that self harm is a way women 'cope' with unbearable experiences, particularly sexual abuse. Burstow (1992) states:

> *Self harm is a way of communicating distress for women who do not feel entitled to speak about the pain or ask for help.* (Burstow 1992)

However, in a study by Bhugra (2002), it is suggested that Asian women are marginally less likely to attempt suicide and relate this to issues such as sexual abuse compared to their White counterparts. The samples of women in this study were contacted after suicide attempts when they were admitted to the accident and emergency services. This sample included both Asian and White women and the sample of Asian women were matched, according to age, with a community group of Asian females attending a General Practitioners surgery. In this study women were asked about their perceived reasons for attempting suicide. The researcher carried out these interviews using, the Culture Identity Schedule (Bhugra et al., 1999), Life Events (Cochrane & Robertson, 1972; Lewis et al., 1992), and the General Health Questionnaire-28 (Goldberg, 1972). The authors failed to consider if their own ethnicity had an impact on the answers given by the sample. If, as Bhugra's (2002) study suggests, that Asian women are less likely to have been sexually abused, then the ethnicity and context in which women were asked about their abuse experiences needs further consideration. It could be argued that women may have experienced sexual, physical and/or emotional abuse but may have not been able to share this information, and the reasons for this needs further consideration. What emerged clearly from the literature reviewed and in other British literature (e.g:

Pembroke, 1994; Arnold, 1995; Liebling et al., 1997; Warner, 2000) is that suicide attempts and self harming appear to be a rational response to violence and brutality, experienced by women, rather than a symptom of a mental illness.

1.5.2 Culture and Identity: Social Factors

There is no doubt that attempted suicide and suicidal behaviours are the result of complex and marked interactions between personal, psychological, emotional, social, biological, and cultural factors. Studies have often considered one or more variables but have not included all of these factors. Consideration of an individual's relationship with their culture and social support system, on the one hand, and their personality and personal coping strategies, on the other hand, is essential for developing a defence strategy. Cultural conflicts may contribute to a sense of hopelessness and helplessness which could push the individual into attempting suicide. As the individual's role changes in response to acculturation along with family values and expectations, the family's perceptions of the act and its role in supporting the individual may become extremely important.

In Hicks and Bhugra (2003) study the findings suggested that Asian women, especially those born in the United Kingdom, had the highest agreement with family pressure as a factor contributing to suicide attempts. This corresponds with other research (Bhugra, Baldwin, et al., 1999) that family conflict was particularly associated with suicide attempts in South Asian women experiencing cultural conflict and identity flux between traditional Asian and Western cultures. A study by Hicks and Bhugra (2000) found that

more highly educated women felt that marital problems and in-law problems were more significant contributing factors to suicide attempts. Therefore, suicide could be related to the distressing predicament faced by some Asian women where husbands and in-laws place pressure on their wives to be educated and productive in culturally mainstream career's whilst at the same time expecting them to remain in traditional Asian women roles. The notion of a 'culture clash or conflict' has also been an explanation of why Asian women experience distress to such a degree that they self harm (Yazdani, 1998). This 'phenomenon' has rarely been explicitly defined and has tended to relate to the disjuncture between the values of traditional Asian culture and those of the Western culture. This is viewed by some authors (see Chantler et al., 2001) as one of the problematic aspects of the post migration experience in Britain, particularly in situations where Asian communities have attempted to retain a high degree of their cultural traditions and norms.

Despite the heterogeneity and diversity in Asian culture, some authors argue that there is also a consciousness that is experienced collectively (Yazdani, 1998). It has been suggested that this shared consciousness, which stems from ancient tradition and which transcends differences in religious beliefs and customs, has an effect on the lives of Asian women and their position in the family and society at large, as the following quote illustrates:

> *There is a certain image ..which cuts across religious boundaries, of which women by and large conform to or question in varying degrees of defiance and revolt.* (Narayan, 1993)

Some feminist writers and organisations have been concerned by the restrictive effects that this shared consciousness can have on the lives of women when taken to extremes (Sahgal, 1990). Others have focused on the positive feelings of identity, solidarity and empowerment that this type of identification has bought to women in Asian communities (Afshar, 1994).

In Bhugra's, (2002) study, the sample of women who were approached by their General Practitioners surgery were interviewed using the Culture Identity schedule, and the results indicate that these women appeared more traditional in their views compared with women who were approached at the emergency services, following a suicide attempt. The women in Bhugra's (2002) study who had attempted suicide were either in mixed race relationships or were in favour of it compared with the control sample. They were also less in favour of arranged marriages. In the same study, two of the attempters had also changed religions and another two were thinking of changing their current religion. This was also found in a study by Bhugra & Desai (2003) who found interracial relationships as a causal factor of suicide, along with approving views of changing religions.

Another issue arising from the studies reviewed was the concept of 'arranged marriages'. This term needs further clarification. It is important to note here that there is a distinction between arranged marriages and those that are forced. As the name implies, forced marriages are where the partners involved have no say in the marriage and where violence may be used to coerce them (Chantler et al., 2003). In Merrill & Owens' (1986) study, they found that out of the 52 Asian women questioned 14 Asian women blamed

their marital problems on arranged marriages that they never wanted. However, this excess of marital problems could be due to the fact that women blamed their marital problems on these unwanted arranged marriages. It is generally accepted that marriages can go wrong for many reasons, and if the marriage is arranged there may be a stronger tendency to blame the 'arrangement' and ignore other relevant factors (Burstow, 1992). Chantler, Burman, Batsleer & Bashir (2001) also asked seven Asian women survivors of suicide, during in depth interviews, their thoughts on what contributed to these suicide attempts. Women stressed that arranged marriages that they were forced into led to their suicide attempts. They additionally recognised the role of agencies which have the responsibility of protecting young women from being forced into marriage, stating that they too should accept their share of the responsibility in allowing these forced marriages.

Suicidal behaviour needs to be studied across the life cycle in relation to gender roles, culture and social expectations. Definitions of the self also differ and are influenced by these factors. Hence, it is important that the individuals' perceptions of self are identified within the context of their culture.

1.5.3 Racism

Racism also emerged in the literature reviewed as one of the contributory factors in self harm and suicide in Asian women. In a study by Chew-Graham, Bashir, Chantler, Burman & Batsleer (2002) they found that older Asian women discussed racism in relation to issues their children faced at school, education and employment. Younger Asian women reported that their experiences of racism was from White peers, who did

not try to understand or listen to their predicaments about culture, and spoke to them using their own stereotypes of Asian families. This seemed to intensify the sense of isolation Asian women reported. Further this study also illustrated that Asian women felt that isolation also existed within Asian communities on the basis of race and gender, with women being identified in terms of their 'Asianness'. Therefore, they were experiencing intrinsic and extrinsic racism, which further increased their sense of isolation. For example a study by Chantler, Burman, Batsleer & Bashir (2001) found through interviews with seven women who had a history of attempted suicide, that some of these Asian women sought 'escape' from an abusive marital situation and moved out to a predominately 'White' area. Women described that they were often subject to racial harassment in the neighbourhood. Merrill & Owens (1986) found that three Asian women who had attempted suicide had been victims of racist bullying at school. The authors suggest that overt racial prejudice was implicated in only three of the twenty nine Asian suicide cases and this may have been due to 'under reporting' of the White professional. Alternatively, racism may have been involved indirectly in the genesis of depression. With respect to this study, it may have been useful to consider these issues by further asking questions about the racism they experienced. Women in the study may not be reporting racism if the ethnicity of the researcher in any way affects the dynamic of the interview. However, Bhugra, Baldwin, Desai & Jacob (1999) found that nearly three quarters of the total sample, of the women who had attempted suicide, acknowledged that racism had played no role in their life events when being questioned.

1.6 The medicalisation of Asian women's distress

Self harm has been cited as evidence of psychopathology for example, Favazza (1989) reports studies which view it as a manifestation of borderline personality disorder (see Walsh and Rosen, 1988), a disorder of impulse control (Pattison and Kahan, 1983) and a multi-impulsive personality disorder (Lacey and Evans, 1986). These diagnoses tend to lead to the justification of continued hospitalisation for many women who self harm. On the other hand, Tantam and Whittaker (1992) criticise personality disorder diagnoses and discuss a deliberate self harm syndrome. Miller (1994) argues self harm is an aspect of a trauma re-enactment syndrome, in which an individual symbolically replays and attempts to resolve childhood trauma. Burstow (1992), Pembroke (1994), Arnold (1995), and Liebling (1997) have challenged the view that self harm is a form of mental disorder and view it as a way women 'cope' with unbearable experiences and distress.

In a study by Bhugra, Baldwin, Desai & Jacob (1999) where Asian women who attended emergency services after suicide attempts were matched with Asian women in a control group, they found significant differences between the groups. Only one woman from the control group had a previous psychiatric history compared with 16, out of the 24, in the group that had attempted suicide. In the Bhugra & Desai (2002) study, they also compared groups and found those that Asian women who attempted suicide were significantly more likely to have a history of previous psychiatric disorder and were more likely to repeat the attempt. Taking these factors into account perhaps it would be useful to carry out longitudinal studies which may give more information with respect to the contributing factors.

However, Hicks & Bhugra (2003) reported that although mental illness has been found to be associated with suicide attempts in South Asian women, this is less frequently present than in suicide attempts by women of other ethnic groups or by men. However, this study did not ask women if they had attempted suicide or experienced depression, which might have affected opinion outcomes. Thus, the possible impact of a history of suicidality or depression on perceived causes is not known for this sample. Also Merrill and Owens (1986) compared ethnic differences in self poisoning and found significantly fewer Asian females that were diagnosed as suffering from a psychiatric illness. Personality disorder was diagnosed fewer in Asian women compared with their White counterparts. It is important to consider the validity of the information obtained in these studies. The diagnosis of psychiatric illness and personality disorder depends both on information supplied by the woman herself and on the assessor's interpretation of it. The assessor's in this study were White and this in it self may have impacted on the assessment.

Additionally, in terms of the sample of women that are married or involved in relationships it is important to consider if the psychiatric diagnosis is not present for the women whether it is present in their partners, and if so whether this has an impact. Chantler, Burman, Batsleer & Bashir (2001) study found that by and large women had not accessed their General Practice prior to their suicide attempts or about their self harming, suggesting that contact with medical services was made after the attempts. What is important is that, in this study, some women explained they were denied access to their doctors by their husbands, particularly those in violent relationships. Prosser (1996)

found that suicides by burnings, for example, are decreasing in women but are on the increase in men. It is interesting to note that the suicides by burning in men, in this study, indicate that in most of the cases men were burning their wives with themselves, hence harming the women. Although the women in this study were not known to services, 18% of the men had a diagnosis of schizophrenia and contact with psychiatric services was predominantly non existent before the suicides.

1.7 Discussion of emerging themes and methodological issues

This review highlighted important emerging themes arising from the selected empirical papers on suicide and self harm in Asian women, born in the United Kingdom. The themes that seemed to offer some explanations for the high incidences of suicide and self harm in Asian women included violence against women, culture and identity issues and racism. Violence against women included sexual and physical abuse often in a marital relationship. Identity issues seemed to stem from cultural and social factors of Asian cultures and this is suggested to be a particular difficult time for many women who are attempting to adjust to two cultures. Racism is also perceived to be a common explanation for the distress women experience, and this racism appeared to exist both within the Asian culture and within the wider society of a Western culture. The medicalisation of Asian women's distress appeared to be problematic as it tended to lead to pathologising the women's distress and sometimes resulted in the underlying reasons for Asian women being ignored. The papers summarised offered little insight into the psychiatric history of the women and lacked any in-depth discussion about how psychiatric information was obtained in the studies.

Most of the studies seemed to lack clarity about how the research was carried out and often as a result there is a lack of reflection on what may have impacted on the outcome of the studies. There is little discussion on the ethnicity of researchers and the contexts in which studies are carried out. One of the main criticisms of the papers is that, although majority of the papers have used qualitative analysis, the analysis is often lacking in depth and further exploration of the findings. The most common method of data collection was the use of focus groups, and analysis is often based on deriving main themes from the discussions. This suggests that the main themes that have been presented in this paper are a reflection of the main themes that have emerged from the focus groups. The flaw here is that this lacks space for individual in depth accounts which are essential for learning about important factors that may contribute to suicide and self harm that women do not feel they can share in group settings. Therefore it appears that the literature in this area is still scarce and patchy, which indicates the need for further qualitative research in this area. Most of the papers are within this decade and are often between the same authors, possibly indicating a lack of interest in this area on a broader level.

All of the studies use samples of women who have come in to contact with some service; either emergency services, general practitioners, women's groups for specialised services and higher risk catchment areas. This approach gives us very little information regarding individuals who do not come into contact with services and it may be that these are the particular areas that could offer further insight. It would, also, be useful to know if there

are women who are not accessing any services, who are particularly distressed and what their thoughts are about services and their 'coping' styles.

Most of the other studies in this review, fail to indicate how these causes or explanations are related, if they are. Clinicians must be aware of the differences between those Asian women who consider suicide, those who attempt it and those who are successful. The association between these three groups and their relationship with other factors needs to be further clarified. Longitudinal studies with this high risk group may give further clues to the contributing factors. A useful suggestion is for future researchers in this field, is to give more consideration to the method of recruiting participants. More attention should be paid to better recruitment and future research should be multicentered and include numbers of Asians who belong to different religions in order to ascertain the important role of religion.

1.8 Summary

This paper aimed to provide a suitable definition of suicide and self harm for Asian women. It is clear from the literature in this area that the definitions vary from experiences and the experiences are vast. The complex nature of this area is evident in the complexities of such definitions. It is fair to suggest that the meanings of suicide and self harm are an interpretation of the individual involved in the act and perhaps a consensus definition is not a practical solution. It is evident that issues such as violence against women, culture and identity and racism all contribute to suicide and self harm but these areas need much more exploration on an individual level. Identification of a non clinical

sample is vital to share light in a broader context and what is the role of services for women who do not access services when they are distressed. Further the medicalisation of Asian women's distress has been discussed which describes the emphasis on pathology tends to ignore the underlying causes of their distress.

It would be helpful to obtain a greater understanding of suicide and self harm in Asian women in the field of clinical psychology. One potential way forward would be an individual case analysis of an Asian women's experience to gain further insight. A theoretical representation of Asian women's experiences of suicide and self harm would also provide a more in-depth understanding. This would enable researchers to highlight relevant themes in more depth that would enable a further contribution to the knowledge base in this under-researched area.

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Chapter II: Empirical Paper I

A grounded theory study exploring mental health issues in British South Asian women

Word count = 5022 (Excluding References)

Submission for publication to: Journal of Community and Applied Social Psychology

2.1 Abstract

Qualitative research investigating mental health issues in Asian women has largely lacked in-depth analysis and has focused on clinical populations. The aim of this study was to adopt a grounded theory approach, using a non-clinical sample, in order to explore Asian women's mental health experiences. Individual semi-structured interviews were conducted with six Asian women. Interviews were transcribed and using Grounded theory a Schematic model representing Asian women's mental health experiences was proposed. Two main themes were identified and illustrated by the schematic model; the East and West cultural selves and a core category depicting an inauthentic style of coping was illustrated. The main findings are explored with reference to relevant theory research. Finally, limitations of the present study, clinical implications and potential future research areas are discussed.

2.2 Introduction

There is a growing body of research on the failure of mainstream mental health services to meet the needs of minority ethnic groups. In his forward to the document Delivering Race Equality, John Reid, secretary of State for Health wrote:

> …there has been a particular concern for a number of years that adequate services and health outcomes have not been delivered to individuals from minority ethnic groups experiencing mental health difficulties. There is clear evidence of the need to transform the services and outcomes experienced by these users and their relatives and carers. The current situation is unacceptable and unsustainable since it contradicts the basic value of equity that is the cornerstone of the NHS.
>
> (Department of Health, 2005)

Two further policy documents make a strong case for action to improve both the experience and outcomes of minority ethnic groups with mental health problems. Firstly, 'Inside Outside' (Department of Health, 2003), which sets the context for the recommendations in Delivering Race and Equality and secondly, 'Mainstreaming Gender and Women's Health' (Department of Health, 2003) that addresses some of the specific concerns of Asian women. Key issues identified in Mainstreaming Gender include a significantly high incidence of self-harm and suicide in young South Asian women compared to any other group of women. However, it is interesting to note that South Asian women are under represented in mainstream Mental Health Services (Gupta,

1991). The term South Asian refers to individuals whose ethnicity originates from countries of the Indian subcontinent: India, Pakistan, Bangladesh, Sri Lanka, Bhutan and Nepal.

Historically, there has been a lack of research in the area of suicide and self-harm in Asian women, but recently journals and empirical papers have addressed these issues. Research has primarily focused on generating themes that offer explanations for Asian women's mental health difficulties. Themes have included issues such as violence against women, suggesting that suicide attempts and self-harm appear to be rational responses to violence in relationships for Asian women (see Hicks & Bhugra, 2003., Chew et al, 2002 and Bhardwarj, 2001). Also culture clash or conflict has also been suggested as contributing to a sense of hopelessness and helplessness for Asian women (see Hicks & Bhugra, 2003., Bhugra et al, 1999 and Yazdani, 1998).

Much of the research has been based on clinical populations which, therefore does not tell us about Asian women who are not accessing mainstream Mental Health Services. Furthermore, the analysis of data has appeared to focus on presenting themes derived from group or individual interviews. There is a lack of theoretical explanations for why Asian women have historically failed to access traditional Mental Health Services. It is the author's view that Clinical Psychology has a vital role to play here.

The aim of the current study is to gather data from a non-clinical population of South

Asian women and to utilise in-depth qualitative analysis to ascertain more detailed information around mental health issues facing this population group. The study also concludes with implications for mental health services.

This area of research is timely because on a national level, the current policy environment is favorable to major changes in the way in which mainstream mental health services are delivered. Together with legislation, including statutory obligations under the Race Relations (Amendment) Act (2000) and the Human Rights Act (1998), it is expected that there will be a major impact on the mental health experiences and outcomes of minority ethnic groups.

In terms of interventions it is important for professionals to understand that individuals from minority groups are not homogeneous but characterised by a range of diversities, including important factors such as religion, languages, cultural traditions and individuality. The current failure of mental health services to cater for and understand cultural and individual differences within cultures leaves many vulnerable individuals without crucial support.

2.3 Method

2.3.1 Qualitative research – Grounded theory

Qualitative methodology was adopted for this research as much of the previous literature in the area of Asian women and mental health has focused on gathering data using quantitative methods. Oakley (2000) states that qualitative methods are often advocated

for research with less powerful groups; including research with women. Qualitative methodology allows for an in-depth understanding of the area under investigation.

Grounded theory was chosen over other qualitative methods because this approach goes beyond thematic description to theory generation. This was felt to be an essential component of the current study given the lack of previous research in this area. Grounded theory has also been described as an appropriate methodology for researching personal experiences, identity and emotions (Charmaz, 1995).

Grounded theory adopts a reflexive approach and this was an important part of the research process. Miles (1983) argues that through a reflexive approach the interviewer assumes the role of empathic listener who neither exploits nor manipulates the researched thus challenging the assumption that scientist's should approach their research with objectivity and emotionless ness.

2.3.2 Ethics

Ethical approval to carry out this study was granted by Warwickshire Ethics Committee (see Appendix 1).

2.3.3 Researcher

At the time of carrying out this study, the researcher was employed as a Trainee Clinical Psychologist in North Warwickshire Primary Care Trust. The researcher describes her clinical approach as informed eclecticism, drawing mainly on person centered perspectives. The researcher is a British Asian woman of south Asian background and by using a qualitative methodology the researcher was able to make clear her own

assumptions and values. This process was imperative during research meetings with co-authors. In order to detail the researchers' thoughts and feelings a reflective diary was kept throughout the research process.

2.3.4 Procedure

Permission was obtained from the managers of three beauty salons catering for Asian women in inner city Birmingham, to advertise and conduct the study in their premises. A poster was placed at each salon (see Appendix 2). Asian women interested in taking part in the study were asked to leave their contact and availability details with each of the managers. The researcher then made contact with all the individuals inquiring about the study. Each individual was asked to attend an initial meeting with the researcher at the salon. During this meeting the aims of the study were outlined and any initial questions or queries were answered. Women left the first meeting with an information leaflet about the study (see Appendix 3), and were asked to contact the researcher within two weeks, if they wished to participate. At this stage individuals were assured that any care they received now or in the future would not be affected by their participation in the study.

Six women contacted the researcher wanting to participate further in the study and a convenient time was arranged to discuss further issues, such as confidentiality and consent. The women were assured that all names and identifying features would be anonymised and that they had the right to withdraw at any stage of the study. Women who verbally agreed to participate were asked to sign the consent form (see Appendix 4), and complete a questionnaire with demographic information (see Appendix 5). They were then asked when they wished to conduct the interviews and times were arranged. A

semi-structured interview schedule including flexible questions about experiences of mental health was used (see Appendix 6). The interviews took place in a private room in the beauty salons. It was important to provide a space that was comfortable to enable rapport to be established between the researcher and participant for the in-depth interview. With the consent of participants, interviews were audio taped and then transcribed. At the end of each interview, it was assured that participants were given appropriate debriefing and support and also supplied with a list of local mental health services. Each participant also received ten pounds as a thank-you gift for their participation.

Age	Marital Status	Dependants	Level of Education	Occupation	Describing Ethnicity	Parents Origin
26	Married	3 Children	HND	Customer Service Officer	British Asian Sikh	India
23	Single	None	BA	Trainee Auditor	British Asian	Pakistan
18	Single	None	A-Levels	Student	Asian British	Father-Pakistan Mother- England
28	Married	1 Child	NNEB	House wife	Asian Pakistani	Pakistan
34	Married	3 Children	A-Levels	House wife	British Asian	India
39	Married	4 Children	School	House wife	Asian	Bangladesh

Table 1: Details of participants

2.3.5 Data sources

The six interviews ranged in length from one to two hours and were transcribed by the researcher. Transcripts were returned to participants with a covering letter asking them to make any amendments they felt necessary and to check accuracy. Reflective and

analytical memos were kept throughout the research process through use of the reflective diary. This was particularly important during the fieldwork part of the research.

2.3.6 Data collection and Analysis

Grounded theory specifically involves processes that are designed to maintain the 'groundedness' of the approach. Data collection and analysis were therefore deliberately inter-related, and initial data analysis was used to direct further data collection. This allowed the density and saturation of recurring categories to be increased over time. It also provided opportunities to follow up any unexpected findings; increased insights and clarified the parameters of the emerging theory (Chamberlain, 1999).

The in-depth, open interview schedule was piloted with one participant initially to test for the comprehension of questions and topic areas. The main data collection, sampling, analysis and coding, proceeded broadly in three phases. The first phase of data collection and analysis involved two interviews to obtain data pertaining to the broad research area. Data was then subjected to open coding, i.e. data was examined closely and analysed line by line to identify initial codes. This stage allows for identification of categories and concepts whilst also ensuring that the theory developed remains close to the data. Hence codes emerged directly from the data rather than from the researcher, who then imposes his/her interpretations on the data collected (Charmaz, 1995). The second stage of analysis involved relational sampling to locate more data to confirm and elaborate categories. Two interviews contributed to this stage. In parallel to this, axial coding took place in order for categories and the interrelationships between categories to be

identified, developed and refined. At this stage of the analysis, memos were used to explain how higher order categories were developed (Giles, 2002). Discriminatory sampling resulted in a third round of interviews involving deliberate and directed selection of further data to confirm and verify the 'core category' and theory as a whole. This ensured that the theoretical account was saturated. Selective coding of data, taken from the last two interviews, led to the identification of the core category and established links with other categories. Saturation of the data was considered to have been achieved when no further categories could be identified and the theory developed appeared to account for all the data obtained.

2.3.7 Reliability and Validity

A number of techniques were adopted to address the issues of reliability and validity. Cresswell (1998) refers to this stage as 'verification' claiming that qualitative methodology is a legitimate mode of inquiry in its own right. The following verification processes took place throughout the study. An audit trail was maintained from the beginning to the end of the research, this enabled research process issues and theory development. A reflective diary was kept by the researcher in order to log personal reflections and check out values and expectations (see Appendix 7). Secondly, memos were kept to help identify analytic ideas such as questions, hypothesis and speculations (see Appendix 8). The memos and diary made implicit thoughts explicit and allowed for an enriching analytic process to develop. Thirdly, two participants contributed in checking the credibility of the findings and interpretations, Chamberlain (1999) states, 'this is the most critical technique for establishing criteria'. Fourthly, the researcher was

involved in a qualitative research group, with three peers, to validate the research process. The group met at different stages of the research and this enabled reflections to be made on previous discussions. Finally, the literature review was delayed until March 2005 to ensure that the emergent theory was as free as possible from preconceived theoretical assumptions.

2.4 Results

Many grounded theorists simply present a descriptive account of the key themes emerging from the analysis and fail to incorporate these themes into a more coherent, substantial model or theory. Grounded theorists believe there is an obligation to the participants to 'tell their stories' to them and others, to give them voice (Glaser & Strauss, 1967). This faithfulness to the data, for it to fit, is a powerful condition of usefulness in the practical life of the theory. Its usefulness can be a matter of understanding as well as of direct application. An attempt has been made here, to go beyond the simple reporting of key themes to additionally present a tentative schematic model of Asian women's experience of mental health. Each stage of the analysis is reported giving examples of the qualitative analysis as well as relevant quotes.

2.4.1 Open Coding

After reading the transcripts through at least twice, meaningful units were bracketed and labeled according to their apparent functional nature as a unit of conversation. The open coding task of labeling participants discussions responded to the following questions:

What appears to be the meaningful cohesive category here? What does this category describe or what is the participant trying to say here? What is the underlying principle of this category? Forty-three categories emerged from the open coding phase and each category was illustrated with an example of raw data from the transcript (see Appendix 9). The following table illustrates examples of some key categories.

Category Number & Description	Example	Number of times category used	Number of participants using category
Feelings of cultural expectations	"I used to feel that I had a pressure, even though people didn't say anything directly..when I mixed with Asian women you always felt the pressure about what wives do and things like that"T1	7	5
Negative images of Mental Health services	"I used to feel like I had this image, I'm going to be dragged away, you know in those asylums or whatever, or where they used to put people away"T1	2	1
Professionals judgments about ethnicity and gender	"He said (GP) Asian people don't suffer with depression"T3	3	2

Table 2: Example Open Coding Categories

2.4.2 Axial Coding

In the axial coding stage, the forty-three categories were collapsed into twenty-eight lower order categories and then into eleven higher order categories (see Appendix 10). This was done by proposing relationships between categories, then consulting the instances of these categories in the transcripts and constructing a logic of association before deciding whether to join them or not. This method, which follows Strauss & Corbin's (1990) 'paradigm model' for linking previously established categories identifies

related phenomena, causal conditions, contexts, facilitating or restraining conditions, action/interactional strategies and consequences of action. In Table 3 are a few examples of lower and higher order categories; for each category notes are also taken from memos, to explain the formation of the higher order categories.

Lower Order categories	Higher Order categories	Memo notes
Lack of control over ones life Unable to communicate with significant others Suicide	"Me Vs The World"	There seems to be a feeling of loneliness that comes from not having control over ones' own life. I suppose there is something about being in a society which largely assumes the significant role of a husband, partner, and if women are not able to communicate with this significant other then is there more isolation. Here suicide seems to be a get out from this aloneness, perhaps the loneliness is exacerbated with an expectation that one can or should confide with a husband or partner.
Influence of Existential beliefs Fixed Personality Factors Lack of control over ones life Suicide	Fate	This seems to link with other categories, not questioning things. Seems to be a process of reinforcing ones situation with the fact that life is a destiny that is controlled by a larger force. Suicide seems to be a test and so if a suicide attempt fails then it was meant to be.

Table 3: Example Lower and Higher Order Categories

These resulting eleven categories were further interrogated by posing a series of problem statements and responding to these with an analytic narrative that probed the relationships among the reduced categories. This interrogation was carried out in order to further collapse the categories and derive a master narrative of the transcripts.

2.4.3 Selective Coding

The final stage of grounded theory is to identify the core category or categories, explicate the story line of the phenomena under study, validate and refine interpretations by further consulting the data. It is difficult to argue that one category is more central to understanding the significance of women's explanation of mental health; nonetheless, a central category of East and West was identified which seems to explain the data. Within this central category is this core category of the 'inauthentic self', which will be explained further.

2.4.4 The Schematic Model

The schematic model of an Asian women's representation of Mental Health experiences illustrated in Figure 1 is now explained. In each of the interviews participants gave an explanation of their experience of mental health and this is illustrated in the schematic model presented (see Figure 1). This model represents an interpretation of the data collected rather than a causal chain of events. The following is a discussion of the main categories contained in this model. The first two categories are the main Asian cultural self; the East, and the wider cultural self; the West, and within these there are descriptions of smaller categories. There is then a discussion about the Asian woman's

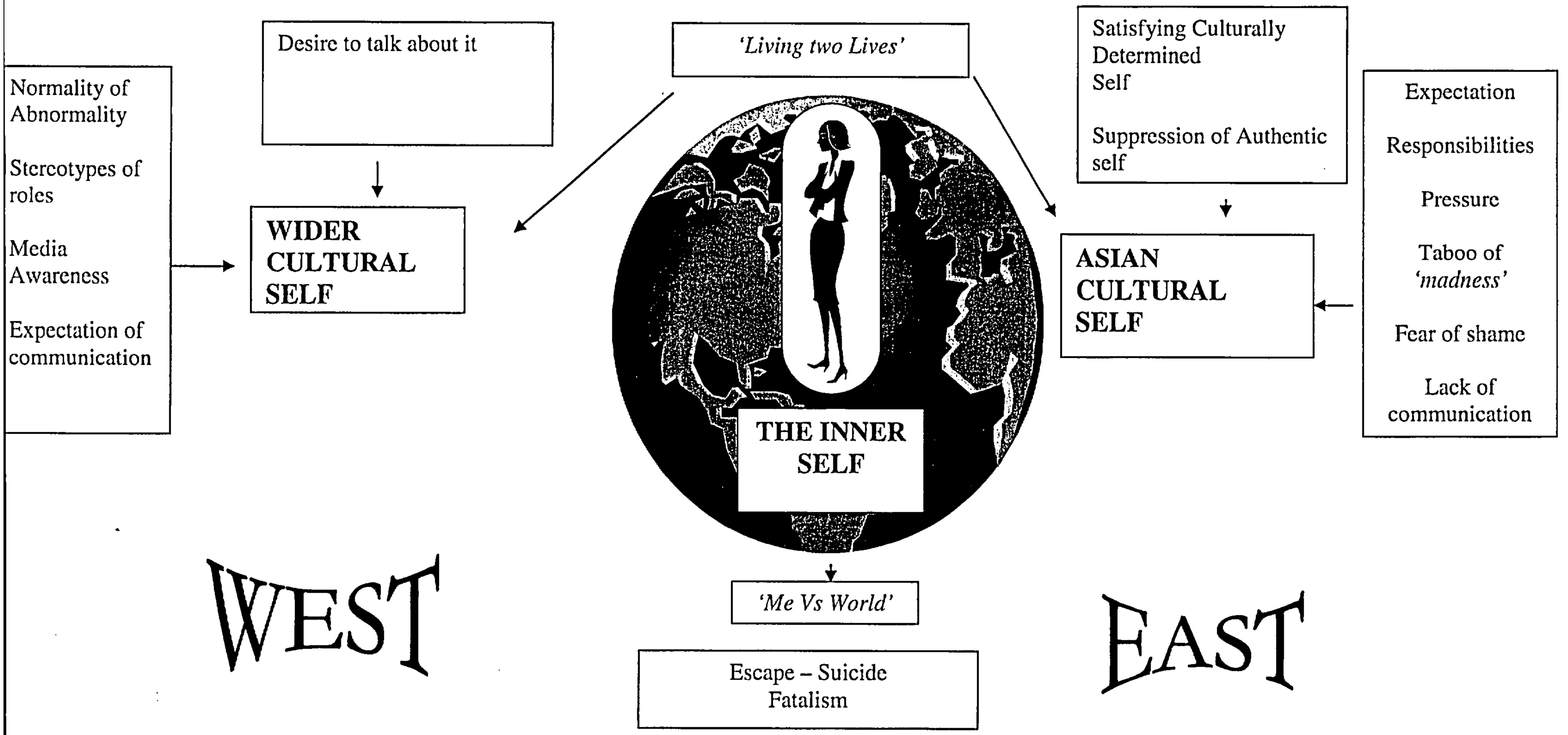

Figure 1. Schematic Model of Asian women's representation of mental health issues

inner world of self, along with a description of the core category the inauthentic self.

2.4.4.1 Asian cultural self- EAST

The Asian cultural self is one of the identities that the Asian women describe they try to collaborate with. This self is illustrated by the expectations of roles of an Asian woman, which includes marital and childbearing roles. The Asian cultural self is, mostly, perceived as a pressure that is almost innate and therefore, even if not desired personally, is unquestioned. This is illustrated by the following quotes:

> *"They (family) feel I have to be a good mother to my children" T1*
>
> *"Well I suppose the normal thing was that when a girl in my family, grows up she needs to settle down and do the whole marriage, children thing. That's what I expected I suppose"T4*
>
> *"You're virtually marrying another family, you don't just marry the man you marry his entire family"T2*
>
> *"By me marrying into the family, it was keeping her (mother) closer to the rest of the family"T4*
>
> *"It's very strange and weird things they (Asian culture) believe in but its one of those things. You can't really do much about it"T2*

The difficulty that the women describe is the inability of questioning the Asian cultural

self because of its existence long before their own existence. The Asian cultural self also incorporates the idea that if other individuals communicate with Asian women, it is important for the other individual to have an understanding of this unquestioning of the cultural self. This is illustrated in the following quote:

> *"It needs to be someone Asian because I think they would have more of a concept of what is believable and what sort of things do and don't happen"T2*

Within the explanation of the Asian cultural self is the category ***Taboo of 'Madness'***, written in this way as it is a vivo term used by two of the women. Often the subject of mental health initiated a discussion about the taboo of this topic within the Asian culture. The sense was that within the Asian culture, mental health evoked the word 'madness' from other Asian individuals. There also seemed to be knowledge of mental health but a lack of open discussion about it, as highlighted by the following quote:

> *"Asians see it as taboo, I mean I know what they are (services) but I think Asians would not tell people if they were using these services because they would think that persons mad, its that madness and something's wrong with them"T6*

The implications of this quote meant that Asian women could not disclose their mental health difficulties and would often not question this suppression of themselves. Linked with this is the category of ***Fear of Shame***, which is clear in all of the interviews. Fear of shame can be described as culturally existing and is vastly evident in the data. It is

described as censorious to disclosing mental health difficulties. This is a fear of others labeling not only the individual but all those connected with her, such as family. Hence, the women talk about their experiences of suppressing their difficulties in order to shield their loved ones from this shame. This shame has a cultural meaning attached to it, which is of great magnitude. The shame is often described as a parent's fear of what their daughter may bring upon the family. It's almost as if there is a feared expectation that the daughter will let the family down and therefore the women give their explanations of how they consider the implications of their actions at every level and often the outcome is to suppress their intrinsic self. This fear is illustrated by the following quotes:

> *"It's that fear isn't it because you don't tell anyone normally and when you do it's scary"T4*
>
> *"I don't think I have ever spoken to anyone about what I have spoken to you about today at all, it's always been in my head"T2*
>
> *"I couldn't tell my folks that never came into the equation, there would have been so much shame on the family, it's just not an option"T1*

2.4.4.2 The wider cultural self - WEST

Women talked about their 'need' to do things they wanted, free of the Asian cultural self and to 'break out' to the wider cultural self. Women appeared to identify mental health as a western concept that they themselves identified with. This is described as the ***normality of abnormality***, meaning that if mental health difficulties are perceived as 'normal' in this wider culture then the self can be 'normal'. That is the one self that normalised the difficulties; for instance when Asian women described their difficulties being recognised

and normalised as one woman stated:

> *"I wanted someone who understands me and I thought to myself a White person would understand more, that is that you can have depression and that's okay"T1*

Media awareness of mental health reinforced the idea that mental health was a western concept and that it is normalised on western television programs, as illustrated by the next quote:

> *"You see like Trisha who does the show, she's been through depression. You see if people like that can talk about it, she's on TV, you think oh gosh it's normal to talk about it"T1*

However, what also seemed to become apparent was the sense of ***stereotyped roles*** that the women described as coming from other individuals in the wider culture that often contradicted Asian women's distress. Women said:

> *"He (GP) said Asian people don't suffer from depression"T1*
>
> *"Oh come on, he (GP) said, you know that's your life, you're a mum and you have to cope with the larger family, that's your life, that's what it's like to be Asian"T5*

The women acknowledged a need to talk about their difficulties and articulated the ***dilemma in confiding with significant others***, which they describe as being initiated

from the wider self expectation which is being able to confide in a partner or husband. In spite of this, the women describe themselves as being 'tied', culturally in marriage, to a whole family not necessarily to one individual. Consequently, there is a need to speak and confide in a significant other that comes from the expectation of the wider cultural self however the Asian cultural self tugs at this by its expectations of using the family as a unit. The following women described these dilemmas:

> *"Our parents didn't talk to us; they came from Pakistan they didn't understand their children growing up here"T4*
>
> *"I was alone, I used to feel alone and my feelings were alone but I used to feel I should be able to just talk to him (husband)"T1*

2.4.4.3 The inner world of self

The Asian woman's inner world of self was the process of attempting to satisfy the two domains; the Asian cultural self and the wider cultural self. The women endeavored to ***satisfy the Asian cultural self*** through their child bearing roles and through their attempt to follow religious attempts in coping with distressing thoughts; these processes seemed culturally acceptable. Parallel to this process was the need to communicate to someone about their inner feelings. Women identified this process as, ***living two lives*** and described this as juggling the pressures and the expectations of the two cultures. During this process, it was apparent, that when pressure built up in excess of their ability to maintain the expectations of the two selves, the process of living to lives became hard to sustain. Here women described thoughts of suicide. This was the stage described as *Me*

VS the World, where women reported an increasingly isolated feeling owing to the lack of understanding of their expectations from others. One woman described this as follows:

> *"There were times that I felt there was no point from going on, because there was too much pressure from everywhere, and I couldn't do anything to get out of it"T5*

An additional facet to this process is the belief in another force which women described as providing explanations for their continued existence after a failed suicide attempt. This was termed ***Fatalism*** and often women, not only regarding suicide, explained life events by way of destiny therefore, a 'lack of control' over their life was a script that women held. For instance one woman said:

> *"It was like my destiny, and I couldn't do anything about it"T2*

This seemed to relate to not questioning of the Asian cultural self, which Asian women portray as a pressurising process from time to time. One could argue that there is a sense of fatalism involved by not questioning the Asian cultural self also.

2.4.4.4 Core Category- Inauthentic Self

Within this schematic model of Asian women's explanation of mental health issues was a core category of the Inauthentic Self. Women described the struggle of living two lives and in keeping this struggle they suppressed their authentic identity. As a consequence an inauthentic self is described. This inauthenticity is presented superficially to others. The

self is subjected to an inauthentic self as a means of coping with the multiple expectations of two almost opposite cultures.

It was evident that most of the women describe this inauthentic self as the real them to others and, at times to themselves. It seems that creating and presenting this inauthentic self is a subliminal process and as a result it is not evident when initially speaking with the women. Subsequently from hearing the explanations of the mental health difficulties and the struggle of satisfying the Asian cultural self along with the wider culture self this inauthenticity then becomes apparent as the emulsion of managing the multiple selves.

2.5 Discussion

A schematic model of Asian women's representation of mental health issues is proposed from analysis of the data obtained. While the model is distinct from other research, a number of aspects support other research into Asian women and mental health. The concept of cultures impacting on the Asian women's mental health offers support to research carried out by Yazdani (1998). Yazdani (1998) put forward the notion of a 'culture clash' as an explanation of why Asian women experience distress to such a degree that they self-harm. This 'phenomenon' is not explicitly defined. However, Yazdani's (1998) research relates it to the disjuncture between the values of traditional Asian culture and that of a Western culture.

Asian women talked about suicide as an 'escape' from extreme conflicts of their selves, supporting Hicks and Bhugra's (2003) findings that there is a link between culture

pressure and suicide attempts. In the present study Asian women described a cognitive process of considering suicide as a way out from their isolated feelings resulting from the expectations and lack of understanding from two cultures.

Additionally, Asian women gave an explanation of why the medicalisation of mental health issues is useful in normalising something that is considered abnormal in the Asian culture. It is evident that Asian women sometimes felt they were not able to disclose mental health issues to other Asians including professionals because of the stereotypes that existed about Asian women's roles. Stereotypes of roles were also evident in their experiences in the Western culture. In Hicks and Bhugra's (2003) study and Merrill and Owen's (1986) study, they inquire about previous psychiatric history in Asian women who had attempted suicide, however, there is a lack of recognition of the impact of the researchers ethnicity on the information supplied. Stereotypical attitudes needs to a considered factor in research.

The core category of the inauthentic self offers support to research highlighting high suicide rates in Asian women (Soni-Raleigh, 1996). Creation of an inauthentic self as a coping style to the pressures of two cultures is depicted as a temporary coping strategy. In the event of pressure exceeding from any one culture or both cultures, the coping style of inauthenticty becomes further strained and even more so isolating. In this present study Asian women describe their sense of *me Vs the world* which links in to the notion of this inauthentic self. Suicide is an option considered when this inauthentic self leads to an excessive sense of isolation.

Although this present study focused primarily on the cultural pressures faced by Asian women which impacted on how Asian women dealt with mental health difficulties, this theory is limited. Asian women in this study do not discuss the implications of other factors in addition to the self that may impact on their mental health. There may be other socioeconomic explanations including issues such as housing, physical health and wealth which affect mental health. There is also a lack of literature in this area and it would be useful to think about incorporating other explanations for psychological distress in Asian women.

2.5.1 Methodological Critique

There were a number of limitations to this study. All of the Asian women interviewed in the study were recruited from beauty salons and it could be argued that women who decided to participate may not be representative of all Asian women. The women attending the beauty salons may possibly be more confident and outgoing then some women who do not attend salons. Having said that, it was important to try and encapsulate experiences from a non-clinical sample and this was the way that it was approached.

In an attempt to maximize theory accountability transcripts were sent back to the participants. Another approach may have been to arrange follow up interviews with participants interviewed earlier in the study in order to test out the theory developed.

Within the literature there was no evidence of studies using a grounded theory approach to understanding Asian women's mental health issues. Grounded theory approach advises researchers to use small samples to gather rich data; however, one may argue that the smaller sample does not allow for generalisations to other Asian women. In order to try and rectify this, the researcher encouraged women of all ages, above consenting age, to participate in the study. This was encouraged to achieve a range of ages to allow for a breadth of data. In this present study the ages, of the women who participated, ranged from eighteen to thirty-nine years.

It is important to consider the ethnicity dynamic between the researcher and participants during this research. The impact, if any, of the researchers Asian ethnicity may have meant that on one level participant's felt comfortable sharing information due to the similarity of the ethnicities. However, on another level it may have meant that the similarity of ethnicities may have hindered the validity of the information given by participants. During the research it was vital a neutral stance was maintained by the researcher and this was consistently reflected upon. Subjectivist epistemologies were employed in this research and by using a reflective approach the researcher was able to reflect on feelings and thoughts that came from doing this work. Also approaching this research using grounded theory meant that consistently the researcher was taking back the findings to the raw data allowing for final analysis to be as close to the participants own thoughts and feelings.

2.5.2 Clinical Implications

There are a number of clinical implications arising from the present research. Asian women experiencing mental health difficulties describe the complexities of disclosing distress and these issues need to be sensitively approached. Asian women approaching contact with services may have been affected by stereotypical expectations from other professionals and so working clinically with Asian women would need good judgment of sensitivity. However, it is vital that this sensitively is not itself a stereotyped position. Each individual entering mental health services, including Asian women, needs to be assessed with regards to their individuality and their own life experiences. It is our own professional responsibility to think about our own stereotypes and how these may be present in the dynamic between client and therapist settings. This should be an essential component in training programs for all professionals with the potential of working with Asian women.

The proposed model provides some helpful information as to why Asian women are not accessing services and identifies the role for more education and training to reduce stigma and the 'taboo of madness' that Asian women describe. Where information is provided this needs further consideration, Asian women describe the lack of awareness in the Asian culture of mental health and therefore work needs to be done on this. Appropriate information needs to be circulated to various services including general practices and other services apart from mental health services.

It is important to consider the inauthentic self if Asian women come into contact with

mental health services. If women are creating this sense of inauthenticity as a coping strategy then it is important that professionals are non-judgmental about their coping. Instead it might be preferable to work with this and support Asian women in the struggle of satisfying the cultures expectations.

One further implication is to consider the role of support in working with Asian women as this study has clearly identified that support from significant others may not always be present and should therefore not be assumed.

2.5.3 Future Research

This study proposed a number of clinical implications for services. Exploration of professionals' perceptions and clinical experience of Asian women and mental health is necessary before planning how services may be developed. This is vital as professionals may have differing views with regards to the services being offered.

In this study, the schematic model represents mental health issues in Asian women which are affected by the concept of self. As this research is grounded the theory is developed from the Asian women's own ideas. However it may be interesting to carry out some research to identify the role of other factors such as physical and sociological factors that may also influence mental health, which were not explored by the current study.

Future research of good quality and well thought out design needs to be explored in this area as there is a limited amount of theoretical research in the area of Asian women and

mental health. It is hoped that through such research Asian women's experiences will help inform clinical services and as a result Asian women will access services in times of particular distress.

Finally, there is very little research in this area despite the fact that British minority ethnic communities have been settled here for a long time. Still little is known about suitability of services for minority groups. In some parts of the UK, such as Leicestershire and Birmingham by 2010 the British minority ethnic population will outnumber the White population (Department of Health, 2003) and yet services are still lacking for these population groups. This is partly because it is a topic area about which little is understood there are few statistics and minority ethnic populations are not accessing services. Also stereotypical attitudes affect how referrals are made and so a viscous cycle continues (Department of Health, 2003). In order to challenge this, research has to start somewhere and it is hoped that this research will be contributing towards this.

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Chapter III: Empirical Paper II

An Asian women's experience of Self-harm and Attempted Suicide

Word count = 3159 (Excluding References)

Submission for publication to: Journal of Community and Applied Social Psychology

3.1 Abstract

Qualitative research investigating an individual Asian woman's experience of self-harm and attempted suicide has largely been neglected. The aim of this study was, therefore, to adopt a phenomenological, idiographic approach, in order to explore such a unique experience. A semi-structured interview was conducted with an Asian female who had a history of attempted suicide and self-harm. The data from the interview was transcribed verbatim and analysed using the idiographic, case study approach to Interpretative Phenomenological Analysis (Smith, Jarman & Osborn, 1999). Four common themes emerged from the analytic process, relating to both the participants attempted suicide and self-harm experience. These themes included Asian culture expectations, fear of disclosure, experiences with services and the concept of an authentic self. Three unique themes emerged from her self-harm experience and three from her attempted suicide experience. The self-harm themes included self-harm is coping, connecting with the authentic self and control. The suicide attempt themes were described as losing control, letting go of the authentic self and finally a process of making sense of a failed suicide attempt. These phenomenological themes are explored with reference to literature in this area. Limitations of the present study focused on conducting this research using a single case design and finally directions for future research support the need for further in-depth qualitative studies in the area of self-harm and suicide in Asian women.

3.2 Introduction

The terms attempted suicide, parasuicide and deliberate self-harm have often been used interchangeably in the literature. For the purpose of this paper the definition of parasuicide is taken according to the ICD-10:

> *"An act with non fatal outcome in which an individual deliberately initiates a non-habitual behaviour that without intervention from others will cause self-harm, deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage and which is aimed at realising changes which the subject desired via the actual or physical consequences."* (ICD-10)

It is important to recognise that individuals explain self-harm or suicide in individual ways and these explanations are important in advancing clinical knowledge (Burstow, 1992). An inspiration for this study came from an article in the Guardian (2000) called 'Suffering in Silence'. This article described increasing rates of attempted suicide and self-harm in south British Asian women and how self-harm was becoming a survival strategy for many women. Soni-Raleigh (1996) in a study of suicide trends, confirmed these high suicide rates among south Asian women.

There have been very few studies of attempted suicide and self-harm in minority ethnic women in the United Kingdom. The studies that have been carried out have mainly utilised focus groups of Asian women searching for meanings of suicide and self-harm. The studies have also predominately focused on clinical populations. Most of the

analyses have concentrated on drawing major themes from the data. It can therefore be argued that in-depth, individual analyses have not been considered.

Definitions of the self differ across cultures and in societies, thereby making an understanding of harm to the self an interesting question. In order to fully understand and support Asian women who self-harm and or attempt suicide, the author argues that it is important to listen to and learn from an Asian woman's subjective experiences.

The aim of the current study was to adopt a phenomenological, idiographic approach, in order to explore a unique, Asian woman's experience of self-harm and attempted suicide. This woman's experience was explored as an idiographic case study, in order to reach a specific understanding which would otherwise have been diluted by trying to develop a more general conceptualisation of Asian woman's experiences of self-harm and attempted suicide. The aim of this study was not to test pre-existing theories and hypotheses, but to let phenomenological and process related themes emerge from the qualitative data and to then interpret this in light of psychological theory. Therefore, the data from a semi-structured interview with the individual were analysed using Smith, Jarman and Osborn's (1999) idiographic, case study approach to Interpretive Phenomenological Analysis (IPA).

3.3 Method

3.3.1 Procedure

The participant was recruited via a poster (see Appendix 2) displayed in a beauty salon in the West Midlands region. The poster invited women to meet with the researcher for an interview for a larger study (Thabusom et al., 2005 unpublished). Women inquiring about the poster, who disclosed self-harm histories, were asked if they would be interviewed about their experiences of self-harm and attempted suicide.

3.3.2 Ethics

It was vital to consider the ethical issues of this study, which was met with approval from Warwickshire Ethics Committee and the University Ethics Committee (see Appendix 1). The researcher followed a range of procedures in order to minimise any potential participant distress (see Appendix 11). The participant's welfare was of paramount importance at all times during the research process. The researcher met with the participant on two occasions prior to the interview to discuss issues such as confidentiality, consent and distress (see Appendix 12 for consent form).

3.3.3 Participant

The participant (who will be referred to as Salma to preserve her anonymity), is a twenty-eight year old Asian female, born in the United Kingdom. Salma is married and has three children. Her parents migrated to the UK from Pakistan in the 1960's and she is the eldest of four sisters. Salma has a history of self-harm since the age of seventeen and currently

describes her self-harm as a 'rare experience'. She has previously been involved with mental health services. However, currently she was not involved with any mental health services. Salma attended the beauty salon regularly and on one occasion made contact with the researcher.

3.3.4 Data Collection

A semi-structured interview schedule was prepared following Smith's suggested stages (Smith, 1995; Smith & Dunworth, 2003, see Appendix 13). The interview schedule included flexible questions regarding the participants self-harm and attempted suicide experience. The schedule tried to incorporate questions that would elicit further understandings and meanings of her experiences; what were the reasons for, how the acts took place and what was the aftermath experience. The interview schedule also attempted to inquire about reflections of what would have helped at the times that Salma harmed her self or attempted suicide. The data was collected over a two hour long, semi-structured interview. This was conducted in a private room in the beauty salon, which was a familiar surrounding of the participant. This was considered to facilitate the participant's comfort and prevent interruptions. Owing to the sensitivity of the interview topic, the interview was structured flexible and the focus was on building a trusting dynamic between researcher and participant. It was important to listen in a non-judgemental and empathic manner in order for the participant to speak as openly as she wished about her experiences. In order to minimise distress, the researcher consistently checked if the participant was comfortable and reminded her of her right to withdraw at

any time. With consent, the interview was audio-taped and transcribed verbatim ready for analysis (see Appendix 14).

3.3.5 Data Analysis

The interview transcript was analysed using Smith, Jarman and Osborn's (1999) idiographic, case study approach of Interpretative Phenomenological Analysis, IPA. IPA is phenomenological in that it aims to get close to and explore in detail the participant's view of the topic under investigation (Smith and Dunworth, 2003). It is interpretative, that the researcher is required to find meaning within the person's experience, having acknowledged his or her own values and assumptions. Paradoxically, the researcher's perspective distances him or her from reaching the 'insider's perspectives' (Conrad, 1987), but also facilitates the dynamic interpretative process.

3.3.6 Researchers Perspective

The main researcher has knowledge of the literature on Asian women and self-harm and attempted suicide and has carried out an intensive literature review in a previous paper. When completing qualitative research, it is imperative that the researcher makes explicit and remains aware of the possible impact of her or his own values and assumptions throughout the research process. It is hoped that this is achieved as the researcher has remained reflective and reflexive throughout the research process. This was done through the use of a reflective research diary, attending a qualitative peer group and through detailed discussions with supervisors (Giles, 2002).

3.3.7 Validity and Reliability

The researcher met with two peer colleagues and two supervisors to discuss the coding and enabled verification of possible interpretations of the data. Ideas about emerging relationships within data were also discussed. Following Smith et al's., (1999) suggestion, these conversations were documented to guide writing up of the analysis. A research diary was also kept throughout this process, which provided an audit trail of the research process (Yin, 1989; Henwood & Pidgeon, 1992). For further validity checks, the researcher fed back the results to the research participant and amended the details as necessary.

3.4 Results

Unlike grounded theory (Stauss & Corbin, 1998), which requires analysts to construct a theoretical model of sorts from the themes, IPA is fairly flexible beyond this stage of analysis. Emerging themes were recorded in the margin of the transcript and checked against earlier parts of the transcript. These themes were then recorded and organised into meaningful clusters (see Appendix 15 for Lower Order Categories). After this stage, themes were reached, based on their frequency of occurrence and their richness. In this instance, four themes were identified that were common to both Salma's experiences of self-harm and suicide attempt. Three themes that were unique for her self-harm experience and three themes that were unique for her attempted suicide experience were also identified. Therefore the analysis differentiates between the common themes and the unique themes (see Figure 1).

INCREASING DISTRESS

SELF HARM

COPING WITH DISTRESS

↓

CONNECTING WITH AUTHENTIC SELF

↓

FEELING IN CONTROL OF DISTRESS

Authentic self

Asian cultural expectations

Fear of disclosure

Experience with services

ATTEMPTED SUICIDE

LOSING CONTROL

↓

SAYING GOODBYE TO AUTHENTIC SELF

↓

MAKING SENSE OF FAILED ATTEMPT

Figure 1. Themes for Self-Harm and Attempted Suicide

3.4.1 Common Themes

Asian culture expectations

In discussion of the experiences that Salma found difficult, she discussed the notion of expectations placed on her due to her Asian culture. These expectations appeared to present a role for her that she felt she had to adhere to. This is illustrated by her following statements:

> *"I was the eldest child..so it was like they were waiting for me to reach a certain age before they could pounce on me (Marriage proposals)."*

This role was also about doing the 'right thing' for her family and protecting their honour. Salma discussed her desire to do the right thing after withholding information about her abortion as follows:

> *"I thought I want to do something that they (family) would be happy with, I felt like I had already let them down."*

The interesting thing here is that Salma did not disclose the abortion experience to the family and holds on to this experience privately. This is confirmed through her lack of opportunities in communicating with her significant others as she states:

> *"I couldn't talk to them (parents) if I could I would have been able to tell them. It wouldn't have come to this."*

Her commitment to adhering to Asian cultural expectations meant that she felt extremely isolated in her suffering, saying:

> *"I was in a world of my own suffering the hurt in silence."*

She described how this isolation continued when she sought help from services. Parallel to this is Salma's own expectation, perhaps culturally driven, that she wanted the family unit to continue supporting her. She said:

> *"..I don't think anybody in my family, at the time, cared about me going to see someone so my heart wasn't in it."*

She shared that the support discontinued when she stepped into what might be construed as an 'alien world', a world of communicating mental distress. This is where Salma discussed the need for Asian cultures to be educated about mental health issues. She described this as follows:

> *"The biggest thing is that they need to advertise better, like in these beauty salons, GP surgery's, or even in the bus. I think the whole culture needs education, maybe religious places, because there are men there often too."*

Fear of disclosure

There was an immense fear present from Salma's experience. This seemed understandable due to the lack of opportunities to discuss her experiences in a safe and supportive environment. She said:

> *"It's something that I haven't done in such a long time and it's difficult."*
>
> *"But to be honest that's why I didn't say anything it was because the shame my family would have gone through, the family would have collapsed and I would have been petrified if that had happened."*

Salma talked about her parents fear which seemed to place responsibility on the Western culture:

> *"It's all Asian parents fear that a daughter brings shame on the family, and the Western culture would have been blamed if I had told them that I had had sex (out of marriage)."*

There was also a fear of religion which is perhaps reinforced culturally:

> *"I felt like someone was watching me saying I know what you've done."*

Experiences with services

Salma discussed her views of the professionals she came into contact with and explained two different experiences. In the first instance, Salma talked about an experience that was not helpful to her and in the second she explained positive experiences:

> *"It was nice to talk but there was a culture clash, there was so much I just didn't have the energy to explain about the culture, I saw this White person and thought I bet you think I'm stupid for hiding all this from my family."*

In the latter quote Salma acknowledged her 'mind-reading' influencing the experience but explained how this came from the professional's lack of empathy, which is drawn from her more positive experiences. She said:

> *"This person put his heart into his work, he was genuine. If he didn't understand he would say 'can you explain and I want to understand', it doesn't matter about race or gender, what matters is he was willing to try and understand."*

> *"I did see someone; they were a life line. I think they helped me so much, that's why I've made it through."*

Salma's different thoughts of her experiences demonstrate that the empathy she received during the positive experience, being listened to and understood, resulted in a better outcome that encouraged in her to speak about her life.

Authentic self

During Salma's interview she discussed all her experiences and interactions with others and the importance of herself within this. This is titled her authentic self as this includes her genuine ideals, thoughts, feelings that could be masked by her interactions with others. During her self-harm and attempt of suicide, Salma discussed her true pain that exists inside the real her. She describes this as follows:

> *"I interacted like a robot the real me was locked up inside."*
>
> *"At night, because there's no pretence I can escape into the world that I always wanted to be in, my world."*

Due to the lack of disclosure of Salma's distress, her authentic self is hidden and she is forced to feel abused by significant others. She states:

> *"I suppose sometimes I used to feel fake, almost abusive like rape in a way, because he (husband) had no idea of what my real feelings were inside."*

3.4.2 Unique Themes

Self-harm is Coping

Salma described her self-harm as a 'coping strategy' for the chaos she felt inside. She said:

> *"Cutting was my only release from the chaos inside, I was in so much pain, still am."*
>
> *"I do hurt myself, but I wouldn't even call it hurting the word I would use is it's my coping thing."*

Self-harm is connecting with her authentic self

Salma described her self-harm as a way of reaching her authentic self and a way of communicating with that side of her. She said:

> *"The pain and scars took me back there and that's good."*
>
> *"There was nothing in my life, I felt empty and the pain was me."*

Further she explained that her self-harm was hidden, just as her authentic self is. She described it as a very intrinsic relationship with herself and states:

> *"But I always did it so that no one else would find out, so all these stories you here about people harming themselves for attention are bullshit."*

Self-harm is control

> *"For me it's mine, it's my way of feeling like I'm in control of that side."*

"I'd get scissors and just slash my arms because all these thoughts were in my head going round and round and I needed to take some control of them."

The above quotes reveal that for Salma the self-harm was being in control. She also explained her control of her eating habits and her sleep deprivation.

"I mean I didn't even used to eat properly that was a way of me harming, again it was something that I could do to myself."

Suicide Attempt losing control

Salma explained that her self-harm was a way of being in control and keeping her distress hidden. However, when this coping strategy failed, Salma discussed the suicide attempt.

"I suppose when I wasn't in control was when I tried to kill myself."

She explained this comes from her lack of energy in maintaining the momentary self coping strategy.

"I couldn't do it anymore, they couldn't understand me and I couldn't pretend anymore, I wanted to give up."

Salma described the pressure as too much and this is because of her experiences of hiding her authentic self and attempts to satisfy her cultural expectations.

"I couldn't fight it anymore, the system was too strong."

Suicide attempt letting go of authentic self

> *"I was crying blood tears because this wasn't the fairy tale I wanted, no where near..with each tablet I was saying goodbye to me."*

Salma's desire to reach her genuine self was failing and her suicide attempt was significant of that. Up to this point she was trying to maintain the authentic side of her and kept it alive but when she decided to let go of her control she then is saying goodbye to her authenticity.

Making sense of a failed suicide attempt

In Salma's experience her suicide attempt failed and she was left with the reality that she was still alive. She then discussed the process of making sense of this experience and for her, religion and fate is significant. She stated:

> *"I remember thinking I'm going to take this as a sign, maybe I'm meant to live, so at that time I decided I was going to."*
>
> *"I knew that in my religion if I had ended my life I would have gone to hell so maybe for me this hell I was living on a day to day basis was better than that hell".*

Despite Salma not saying this directly in her interview, she seemed to present her self-harm as her coping strategy for her present difficulties however she admitted to harming very infrequently now. After the failure of her suicide attempt one could argue that the cycle of self-harm she was previously in continues to persist. Self-harm continues to be

used as a coping strategy, without the intention to end her life. It is only likely that this triggers a suicide attempt when pressures on Salma exceed her ability to cope above and beyond her self-harming coping.

3.5 Discussion

A phenomenological, idiographic approach was adopted in order to explore a unique Asian woman's experience of self-harm and attempted suicide. Four common themes emerged from the analysis of a semi-structured interview, for both suicide and self-harm experiences. These included Asian cultural expectations, fear of disclosure, experiences with services and the authentic self. These themes were consistent throughout the interview. Unique themes also emerged from the data for explaining the experience of self-harm and the experience of attempted suicide. In terms of Salma's self-harm experience three themes emerged. Firstly self-harm meant she was coping with her distress. Secondly it enabled her to connect with her authentic self and finally she felt she was in control of her distress and pain through her self-harm. In terms of Salma's attempted suicide, three themes also emerged. Firstly the attempting suicide meant she was losing control and the distress was out of control. Secondly it meant she was letting go of her authentic self and saying goodbye to her true self. Finally, after her failure of suicide, she makes sense of the experience through religion and fate, providing explanations for her continued existence. Salma continues to self-harm after her suicide attempt fails and reinforces her self-harm as her coping strategy.

Salma's use of self-harm as her coping is also consistent with the literature on self-harm (Burstow, 1992) as well as remaining in control (Miller; 1994; Liebling et al; 1997).

It is important to consider the ethnicity dynamic between the researcher and participant during this research. The impact, if any, of the researcher's Asian ethnicity may have meant that on one level the participant felt comfortable sharing information due to the similarity of the ethnicities. However, on another level it may have meant that the similarity of ethnicities may have hindered the validity of the information given by participant. During the research it was vital a neutral stance was maintained by the researcher and this was consistently reflected upon.

3.5.1 Limitations

It is hoped that this case study contributes to our understanding of possible experiences and processes involved in Asian women self-harming and attempting suicide. However, this study reached a specific and unique understanding of an individual's experience of self-harm and attempted suicide. Therefore, the authors would apply caution about generalising the findings across other Asian women who self-harm or have a history of attempted suicide.

3.5.2 Future research and clinical implications

This area of study is vital due to the high prevalence of suicide and self-harm in Asian women (Soni-Raleigh, 1996). It is hoped that the present study will stimulate further idiographic investigation. Further research needs to address methodological issues

regarding confounding variables and lack of in depth analysis. This study has attempted to do this by using an individual case study approach which involves a thorough analysis of the data using a very open ended interview guide to allow for emergence of any findings. In addition, this study recruited a participant from a non-clinical population.

Clinically, we need to develop our knowledge base further via qualitative research investigating personal experiences of women. This type of methodology allows us to investigate in-depth personal experiences that can lead Asian women to self-harm and attempt to take their lives. Through use of qualitative methodology, we must develop our understanding of the phenomena and processes involved in using self-harm and attempting suicide from an Asian woman's perspective. This knowledge can then be used to inform the practice of professionals working with individuals with mental health difficulties.

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Chapter 4: Reflective Paper

Reflections on the research journey:
Harder the villain, greater the hero!

4.1 Introduction

My research thesis in Clinical Psychology includes a literature review of suicide and self-harm in South Asian women, a grounded theory study exploring mental health issues in British South Asian women and a case study of an Asian woman's experience of self-harm and attempted suicide. The aim of this review paper is to take a reflective stance on the process of carrying out this research thesis. The paper will cover the following; the reason why I chose this research area, ethnicity issues, the use of qualitative methodology, my personal reflections of carrying out this research and finally integrating research into clinical practice.

4.2 Research area

Who would have thought leg waxing, hair straightening and lip gloss would have instigated a thesis?

The idea for my research initially arose from an article I came across in the Guardian (2000) titled 'Suffering in silence' which illustrated a high incidence of self-harm in Asian women. I recall thinking at the time that it would be an interesting area to do some research in and I found myself collecting material over the years that seemed to support this perception that Asian women suffer in silence. Soon after, I stumbled upon an old acquaintance who informed me that she was managing a beauty salon catering for Asian women. We began to talk about her new venture and she shared something that intrigued my interest in Asian women and mental health issues even further. In the course of our conversation I became aware that her beauty salon was often used as a type of 'base' for Asian women to come and share their stories with other women. These women regularly spoke of distress, despair and crises in their lives. It was almost as if a light bulb had switched on. I began thinking about and then

persuing the following question: Why Asian women are self-harming and attempting suicide at such an increased rate (Soni-Raleigh, 1996) and could the women attending the beauty salons, offer some insight into this? Following this I wondered whether mental health services could learn from these women's stories and whether this type of research could expand our clinical knowledge for working with Asian women. After some detailed discussions and meetings, the research thesis journey began. Needless to say my visits to the beauty salon increased over the end of my second year.

4.3 Ethnicity

As the researcher in the interview dynamic I found myself making clear my role, I often used my reflective diary to support me through this process. As an Asian woman myself interviewing participants who were also Asian meant that a further dynamic existed, in this instance both participants and researcher were from a minority ethnic population. This was an important concept in the research and I shall attempt to share my reflections on this dynamic.

At one level, I found myself close to the participants more then ever I imagined I would be and this was perhaps a reflection of the in-depth data collection and analytical process. It seemed as though there were fewer boundaries when these women spoke to me, and because I shared the same ethnicity I was one of them. On another level, I felt distant towards the women because I consciously tried to remain in a neutral position. I asked few questions, spoke little and avoided getting involved in the general 'banter.' I suppose on reflection this was my way of holding onto my schema as a researcher and it was imperative to hold that role in my mind. Overall I

found that the shared ethnicity was a positive contribution which allowed me to get into other Asian women's 'world' as they seemed to trust me; this is marked through the 'you know what I mean' quotes in the research.

In addition it was vital that my neutral position did not send the wrong message about the power dynamics that could have been perceived i.e., 'me as the researcher' being more powerful than the participants. I often felt the need to share common quotes used in the Asian culture, in order to identify with the women, making them aware that I was also aware of my ethnicity as an Asian woman. This seemed a weighty process of the research thesis and one which I pondered over from the moment it began to the moment it was completed.

4.4 Qualitative research

In qualitative research the researcher needs to be appropriately prepared (Guba & Lincoln, 1985). I read through literature on qualitative methodologies in the early stages of the research thesis (Willig, 2001; Giles, 2002) to refresh my memory of conducting qualitative research. Through the preparation I was encouraged to consider various practical questions such as the purpose of my research and the best method of data collection to enable the participants' voices to be heard. Two different qualitative methods were chosen for chapters two and three. Grounded theory was chosen over other qualitative methods in chapter two as the approach involves' theory generation, which was important given the lack of research on Asian women and mental health. Grounded theory is a well established qualitative method and has been referenced in many papers (Glasser & Strauss, 1967). Interpretative Phenomenological Analysis, IPA (Smith, Jarman & Osborn, 1999) was chosen for

chapter three as it seemed an appropriate method for a qualitative case study because of its commitment to the phenomenological perspective. I valued the method for its explicit acknowledgment that access to the personal world of a participant depends on, and is complicated by, the researchers own conceptions, because I believe this facilitates a commitment to transparency between the data and its interpretation.

Grounded theory and IPA share a number of common features, including systemic coding and categorisation (Willig, 2001). Both methodologies allow the researcher to be creative and explore meanings that may not be possible with other methodologies. In addition, the two methods place demands on the researcher which require becoming comfortable with flexibility and not knowing where and when the research will end. From using qualitative research, I became aware of the extensive work that was involved. In particular I accepted that uncertainty is part of the process.

4.5 Personal reflections

'Isolated roads lead to greener pastures'

When I first embarked on this thesis process in the area of Asian women and mental health, I was aware that I was excited at the prospect of doing some research in an area that I had a great interest in. Having said that, I knew this research would be difficult to complete and it would no doubt test my patience. I was not aware of where it would take me and how this would affect me personally and professionally. All sorts of emotions emerged through this process. Excitement, enthusiasm, motivation, and a feeling of doing something beneficial for my profession; these were the positive ones. However the other more negative emotions that emerged were more powerful because they were frightening at times to say the least. These were disillusion, panic,

neediness, and most of all the imprisonment of the passion I initially began this research thesis with. I tried physically taking myself to many places just to keep finding myself in all this work and to hold on to that passion I first began with. Occasionally the place was my desk but more often the visits included long car drives in which I took time to reflect. As the process of doing the thesis demanded more of me my drives got longer and my thoughts deeper.

Initially thinking about the research was fine and tweaking through the practicalities of ethics was stressful, although it was supportive that other colleagues were involved in the same process; some how there was a shared thought process that seemed cathartic. It seemed to strengthen the pitfalls of ethics submission and the grilling of ethics committees. It was only when I started conducting the interviews for my empirical papers that I began to feel something different, something isolating. I was enthusiastic hearing about Asian women's experiences, their thoughts and feelings; this is where my passion was. It was so powerful; I really felt honoured hearing their stories. However, it was also a frustrating process. Often the stories I heard, from the Asian women I spoke to, indicated distress, isolated distress with very little support from others. It seemed that the Asian women were so far from reaching mental health services and yet with professional help their distress may well have been reduced. The frustration for me while doing this research was that I also began to feel that sense of isolation. Perhaps it was transference in the dynamic of the interviews, it could have been about issues of isolation that also resonated with me regarding my own ethnicity. I constantly sought reassurance from my supervisors as I felt they were more at the periphery surrounding the process as apposed to being directly involved in the research; this often helped me sought through some of the counter-transference issues.

I also thought consulting with my supervisors would help validate my work and do justice to the stories of the women I had spoken to.

A few days before thesis submission I was particularly anxious, and of course there was some natural anxiety about handing in the work but I had done my work it was something else, something on a deeper level. I once again drove distant from my work to clear my thoughts and reflect on what this was all about. After some time alone I became aware of another process that I had been going through which was blinkered with the technicalities of formatting and binding my thesis. I became aware that I was feeling a sense of responsibility. I was doing this work for the voices of Asian women who had not spoken of their distress before. It was a huge responsibility and I wanted to make sure I was accurately illustrating their views. However, this process deepens further and this is where the greener pastures come to view. Not only were these Asian women speaking about their mental health issues, some for the very first time, but I myself was going through a first time process too. I was the first Asian women in my entire family, that had taken an educational step forward and the panic came from this. It is evident from the research that I carried out with the Asian women that they faced many cultural pressures and I suppose coming towards submission I was becoming aware of my own cultural pressures. In the midst of my academic expectations I had the cultural pressures which did not necessarily support the idea of women in education. So by submitting this thesis and arriving at the end of this research journey, a small opening for other women in my own family and within the Asian community that I came from, was envisaged. Hence, my panic and enthusiasm to end this journey well became both an academic and cultural challenge.

4.6 Integrating research with clinical practice

Clinical Psychologists in today's National Health Service work under great pressure. Despite the emphasis on clinical governance, the system of steps and procedures adopted by the National Health Service to ensure that clients receive the highest possible care, Clinical Psychologists find precious little scope to make the distinctive research contribution. However, the need for theory-driven data is essential in informing our clinical practice and ensuring we achieve this objective.

Integrating research with clinical practice does not necessarily imply that strictly adhered scientific approaches will only satisfy this aim. We are equipped in other ways which will additionally inform our practice, and by this I am referring to reflective processes. As clinicians, our paths will cross many experiences that may render us feeling surprised with the outcome. If through such experiences we take a moment to reflect we learn something from this. Schon (1992) terms this process as 'reflection-in-action', he suggests:

> *"When we go about our intuitive performance of professional lives, we show ourselves that we are knowledgeable in our way. Often, we cannot say what we know...This process is reflecting which is achieved in turning our thoughts back on to what we know already and what we are meeting for the first time."*

Clearly what practitioners know already, what kinds of competences they hold, and what ones stance is in practice, will impact on this learning process.

4.7 Conclusion

I intend to publish the papers included in this thesis because of the dedication of the Asian women involved in this research and to give it its greatest value by sharing their stories. I hope it will be a useful contribution to the existing literature. My research journey has impacted on my personal and professional development and taken me to places I was not expecting. I endeavour to learn more through my future research journeys which I hope will be as challenging and gratifying as this experience has been. This learning could not have been taught in any other way and I feel fortunate to have travelled here.

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List of Appendices

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Appendix 1

thical approval from Warwickshire Local Research Ethics Committee

Warwickshire Local Research Ethics Committee
Recognised by COREC to review Type 2 MREC Applications
Lewes House
George Eliot Hospital
College Street
Nuneaton
Warwickshire
CV10 7DJ

Tel: 02476 865244
Fax: 02476 865264
pat.horwell@geh.nhs.uk

04 April 2005

Miss Shazma Thabusom
Clinical Psychologist in Training
Coventry University
School of Health and Social Sciences
Priory Street
Coventry
CV1 5FB

Dear Miss Thabusom

Full title of study: ***Exploring mental health issues in British Asian women: implications and recommendations for Mental Health Services***
REC reference number: ***04/Q2803/108***
Protocol number: ***2***

Thank you for your letter of 04 April 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application	1	03/11/2004	03/11/2004
Investigator CV	1	03/11/2004	03/11/2004
Protocol	1	03/11/2004	03/11/2004
Protocol	2	04/04/2005	04/04/2005
Letter from Sponsor		08/10/2004	03/11/2004
Interview	1	03/11/2004	03/11/2004

Schedules/Topic Guides			
Copy of Questionnaire	1	03/11/2004	03/11/2004
Participant Information Sheet	1	03/11/2004	03/11/2004
Participant Consent Form	1	03/11/2004	03/11/2004
Response to Request for Further Information	2	04/04/2005	04/04/2005

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q2803/108	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project,

Yours sincerely,

Paul Hamilton
Chair

Enclosures *List of names and professions of members who were present at the meeting and those who submitted written comments*

Standard approval conditions

Site approval form (SF1)

Appendix 2

Advertisement poster
(Empirical Paper 1 & 2)

Exploring Mental Health issues in British Asian women.

My name is Shazma Thabusom, I am a Trainee Clinical Psychologist and I am doing some research on exploring mental health issues in British Asian women.

Mental Health professionals want to improve the services that are currently available. It is hoped that this research will provide further understanding about your perceptions about mental health issues. The aim of this research is to learn from you.

The research involves talking to me about your thoughts on mental health issues which we can do at this salon. If you are interested in taking part then please contact the manager of this salon and they will take your name and contact details.

I will then contact you and arrange a time to meet with you at this salon. We can then discuss the research and I will be happy to answer any of your questions. I will provide you with all the information about the research when we meet and you can decide if you wish to take part or not.

Shazma Thabusom
Trainee Clinical Psychologist

Appendix 3

Participant Information Leaflet
(Empirical Paper 1)

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)
School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300

THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Your ref

Date

Participant Information Leaflet

Exploring mental health issues in British Asian women: considering implications and recommendations for Mental Health Services.

Please read this leaflet carefully before taking part in this research. It contains information about the research project. The information in this leaflet will help you decide whether or not you wish to take part in this research. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information.

What is the purpose of this research?

Mental Health professionals realise the need to improve the services that are currently available.

The aim of this research is to learn about how mental health issues are perceived by British Asian women who are of South Asian origin. The aim is also to explore the impact of mental health difficulties and how Asian women deal with the difficulties.
It is hoped this research will provide further understanding about your perceptions of mental health and mental health services.

Who is organising this research?

This research is organised by Shazma Thabusom, Trainee Clinical Psychologist, as part of her research thesis for the Universities of Coventry and Warwick Clinical Psychology Doctorate.
Helen Liebling (Lecturer in Clinical Psychology), David Giles (Senior Lecturer in Clinical Psychology) and Haseena Lockhart (Clinical Psychologist) are supervising this research.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information to keep and you will be asked

to sign a consent form after having the opportunity to speak with the researcher on one occasion. If you decide to take part you are still free to withdraw at any time and without giving reason. Your decision about taking part in this research will not affect the care that you receive now or in the future.

What does it involve?
If you would like to take part in the study, you will meet with the researcher at which stage you may wish to seek further clarification. If you agree to take part this meeting will also involve signing the consent form. After this meeting, you will take part in an interview at this salon with myself. The interview may last between 1 and 2 hours and you are able to leave at any time if you wish. The discussion will be tape recorded so that I am able to transcribe all the information you give me. I will transcribe the tapes myself. Once the research is completed the tapes will be erased and all the information destroyed.

Are there any disadvantages or risks to taking part?
The main disadvantage is the time required to take part in the interview. It will be a <u>one off</u> meeting. I am aware that providing this time may be difficult for some however; this time will allow for a detailed discussion and will provide meaningful information.

You may also find that talking about your experiences may be distressing. If you find that you are distressed at any stage of the process, then <u>please</u> speak to the researcher at any time.
As the researcher, I will also be able to provide information about appropriate services and support that you will be able to access following this research, if required.

Are there any benefits to taking part?
There is no direct personal benefit to taking part in this research but I hope you will find it beneficial. However, it is hoped that the information that is obtained from this research will inform mental health professionals who are working with Asian Women. It is hoped this information will also improve the services offered in the future.

Will my taking part in this research be kept confidential?
All the information, which is collected during this study, will be kept <u>strictly confidential</u>. Your name is NOT required in any of the research

and if names are mentioned in the interview they will be deleted from the transcription. When information is reported a code name will be given to ensure confidentiality so that people reading the research will not be able to recognise you as a participant. I will be the only person who will enter the information from the tapes onto the computer and this data will be saved, using a password know only to me.

Ethics Approval
Warwickshire Local Research Ethics Committee has approved this research.

What will happen to the results?
The results of the research will be written up as part of the Doctorate in Clinical Psychology, which the researcher is currently undertaking. This will be submitted for publication in relevant academic journals.

Any person who wishes to have copies of the research results or details of journal publications can contact the researcher (details below).

Contact Details
Shazma Thabusom, Trainee Clinical Psychologist

Address: Clinical Psychology Doctorate
School of Health and Social Sciences, Coventry University,
Priory Street, Coventry, CV1 5FB
Telephone: 024 7688 7806
E-Mail: thabusom@hotmail.com

Please do not hesitate to contact me if you would like any further information or if you have any questions regarding this research project. Thank you very much for reading this and taking part in the research.

Appendix 4

Participant Consent Form
(Empirical Paper 1)

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin,Foren)

School of Health and Social Sciences
Coventry University
Priory Street Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8300

THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

PARTICIPANT CONSENT FORM

Our ref

Your ref

Date

Title of Project: **A grounded theory approach to exploring mental health issues in British south Asian women**

Name of Researcher: **Shazma Thabusom**

Please tick box

1. **I confirm that I have read and understood the information leaflet for the above named study and have had the opportunity to ask questions.** ☐

2. **I understand that my participation is completely voluntary and that I am free to withdraw at any time, without giving any reason. I understand that my employment and legal rights as well as my health care provision will not be affected in any way.** ☐

3. **I agree to the interview being taped.** ☐

4. **I agree to take part in the above named study.** ☐

Name of Participant	**Signature**	**Date**
Name of Researcher	**Signature**	**Date**

One copy for Participant; One copy for Researcher

Dean of School of Health and Social Sciences Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Telephone 024 7679 5805
Chair of Department of Psychology Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Telephone 024 7652 3096

Appendix 5

Participant Demographic Form
(Empirical Paper 1)

Programme Director
Doctorate Course in Clinical Psychology
Dr Delia Cushway
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THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

Our ref

Your ref

Date

DEMOGRAHIC QUESTIONNAIRE

Thank you for agreeing to take part in this interview. Your participation in this research is important to the Clinical Psychology profession.

It would be helpful if you could complete this page even if you decide not to take part in the interview.

THANK YOU

Age:…….. **Gender:……**

Marital Status: (please tick)

Married Single Divorced Widowed Separated Co-habiting

Do you have any dependants? If yes, please give details:

……

What is your education level?

……

What is your occupation?

……

How would you best describe your ethnicity?

……

Where were your parents born?

……

Dean of School of Health and Social Sciences Dr Linda Merriman Mphil PhD DoodM CertEd Coventry University Priory Street Coventry CV1 5FB Telephone 024 7679 5805
Chair of Department of Psychology Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Telephone 024 7652 3096

Appendix 6

Semi-structured Interview Schedule
(Empirical Paper 1)

Interview Questions and Prompts for Exploring Mental Health issues in British Asian Women

1) Could you tell me a little about yourself?
(Family, Children, Work etc)

2) Could you tell me about a time in your life when you felt under pressure?
(Or a time when you've been upset)

3) What areas of your life were affected?
(Family, Work, Children, Spirituality etc)

4) How did you deal with it?
(What was helpful/not helpful?)

5) What do you are the main pressures in life these days?
(What do you think people may have done in the past to deal with the pressures of life, what do you think they do now?)

6) What kind of things do you think could help/do help to ease the pressures of life?

7) Can you tell me what you know about Mental Health Services?
(Have you ever accessed these services, or thought about accessing these services?)

8) If you have not used Mental Health Services, do you know anyone who has?
(What were their experiences/perceptions?)

9) Do you know whether there are Asian Women's Services available? Which ones have you heard about/used?

10) What would need to happen for you to use Mental Health Services? How would mental health services need to change in order for you to use them?

Appendix 7

Excerpt from Reflective Diary
(Empirical Paper 1)

DIARY

First interview diary notes

It is really strange, feeling a little frustrated after doing this interview. This immense pressure this woman describes, possibly picking up on that. In fact feel a little annoyed too. The stereotypical comments made to this woman about her mental health from professionals. It just shows how much these voices are suppressed. I was really glad that I am using grounded theory; it allowed me to remain quite and observant at stages and not ask much. It just went where she wanted it to go and it feels so much richer than collecting direct answers. In a way I feel that the pressure was not there for the woman I was speaking to. It seemed as though she initially was expecting to answer questions but soon began to flow with her story, I suppose. I suppose there's something in this for me that I am the professional in this dynamic and I can get drawn into feeling almost apologetic for these stereotypes. It will be important to keep a closer look at this dynamic and try and set my mind in researcher mode and not clinician.

Second interview diary notes

This woman was particularly focused on building a good rapport and I gathered as the interview continued she wanted to talk freely. Perhaps it was her checking out if I would collaborate in her wanting to talk. It was really important that I remained neutral and not make any sudden breaks. She was wanting to share her story but from previous experiences it feels as though she was expecting to be judged. I felt the need to consistently explain the nature of the research with her. That was probably because I sensed she was wondering if there was a hidden agenda, perhaps fearing that my forms have a mental health trust title. If this is her first experience of speaking with someone from mental health and she seemed a little cautious it was important for me to respond in the most sensitivity I could apply.

Appendix 8

Excerpt from Memo Notes
(Empirical Paper 1)

MEMO NOTES

ME VS WORLD

Several of the transcripts identified a struggle of 'me Vs the world' that originates from pressures of cultures such as role expectations, etc. It is interesting to consider the impact of fate here. The Asian women often perceived themselves against the rest of the world due to this struggle of 'me Vs the world'. This often led to a sense of isolation. When the Asian women felt this isolation they described thoughts of suicide as a way out. Here fate seemed to play an important role and a powerful one at that. Asian women relied on fate to make sense of their existence. Describing this process the women indicated that they had thought if they have not attempted suicide, even with such pressures, then perhaps there is a need for their existence and it is meant to be this way. So hence, women are indicating that there is a greater force then themselves, almost controlling whether they live or not.

INAUTHENTICITY

A consistent theme of consciously hiding what is happening inside. Makes links with expectations of self perhaps. Perhaps this is hidden suffering, because it's talked about with pain. Sense of isolation, is this linked with the other theme? Perhaps this is isolated pain. There is a strong sense of fake ness, are these women faking the true self to hide away what is real? So what is real self? is it what's expected and if what is expected is not to show what is really you then the real self will remain inside and there will be a real self that is performed or displayed to the world.

There is the feeling of living two lives and experiences of racism influence a sense of questioning of ones identity. Many of the interviews discuss the struggle to identify themselves and a process of trying to find a balance between being Asian and living in a western society. They are talked about as two different cultures and there seems to be a stage of questioning who am I? This seems to cause lots of tension. A tension that is more exacerbated by expectations of roles of Asian women and racism, is this what others have said is culture conflict?

UNDERSTANDING THE ASIAN CULTURE SIDE

Speaking to someone who was of same ethnicity seems to come up a few times and the explanation given is that there is this shared understanding. Again there's a link with other constructs. Does this relate to the belief ideas? Is there an important area here to think about, perhaps this is linked with the fact that there if someone is of the same culture or ethnicity than this implies that there will not be questioning of beliefs. If this is the case then can someone who is not necessarily of the same culture or ethnicity have mutual culture ness? The women have described a really important idea here; the reason its important for this mutual ness to be present is so that one is understood and one is assumed to understand if they are from similar cultures but I wonder if this can exist regardless of what culture one is from, so long as there is an understanding about cultures. This feels like women are saying they don't want to explain things they want things to be understood. Important for professionals to consider this, is this a factor that causes a barrier in some therapy where externally there is a difference present in ethnicity, is there a clear difference in understandings? Women are saying speaking to someone who is Asian is helpful and it's because they don't feel the need to explain the basics of the culture. But as professionals, our work should overcome this barrier by more understanding, not stereotypes but understanding.

Appendix 9

List of Open Coding
(Empirical Paper 1)

OPEN CODING CATERGORIES

Category number and description	*Example*	*Tokens in Category*
1. This interview being the first time issues are discussed	"I don't think I've ever spoken to anyone about what I've spoken to you about today at all"T2	3
2. Feelings being inside	"It was too much to have inside my head"T4	4
3. Reared to keep things inside of oneself	"you're bought up with what's inside stays inside"T2	1
4. Fear of mentioning feelings to others outside of family	"It's that fear isn't it because you don't tell outsiders normally and when you do it's scary"T4	4
5. Implicit pressure from others about what is expected about the individual, unspoken	"I used to feel that I had a pressure, even though people didn't say anything directly…when I mixed with Asian women,…you always felt the pressure about what wives do and things like that"T1	7
6. Expectations of marriage and wife roles established through family and culture	"Well I suppose the normal thing was that when a girl in my family, grows up she needs to settle down and do the whole marriage, children thing. That's what's expected I suppose."T4	6
7. Emphasis of goodness in roles that are ascribed to the individual by family and therefore are tried to maintained by individual	"They (family) feel I have to be a good mother to my children"T1	5

8. Reference to marriage being functional for the larger extended family, serving a strengthening purpose	" By me marrying into the family, it was keeping her (mother) closer to her family"T4	4
9.Marriage being described as marrying the family not one individual	"You're virtually marrying another family, you don't just marry the man you marry his entire family"T2	2
10. Learnt rules about what a female role can and cannot do	" I can't study travel and tourism for example cause girls aren't allowed to travel on their own."T5	2
11. Reference to differential expectations of the individual due to ethnicity and gender	"They will (her daughters) have to do well because not only are they Asian they are women, they have to work much harder, people have to look beyond their colour and gender for them to do well"T1	1
12. Expectation of a certain time to get married in from larger system	"I can't take longer (reference to education) because I will have to get married before a certain age"T5	3
13. Description to living or trying to live two lives	"It was a shock I never thought I was going to live two lives as I got older, I was trying to fit in all my roles"T1	2
14. Racism experience leading to questioning own identity	"..also experiencing racism, gosh that makes you feel I'm not actually British or you know people don't see me as who I am"T1	1
15. Speaking to someone who is also Asian is seen as helpful	" We talk and because we've got similar backgrounds she understands"T6	3

16. Explanation of beliefs within culture that are not questioned	"It's very very strange and weird things they (culture) believe in buts its one of those things. You can't really do much about it."T2	2
17. The family giving restricted choices which are described as free choices, 'being allowed'	"He said (father) you have to go to Pakistan and have a look, you can choose whoever you want. That was the choice he gave me. I thought that's not choosing"T4	5
18. Describing being let down by the family, the system	"They had a wedding..and I had only just had a miscarriage . I was lying in bed absolutely in agony and they all went to this wedding. The whole lot of them."T2	3
19. Having to keep the family image and honour	"This is your first day at college, my dad said, I want you to come away as you went in. don't let us down.."T3	3
20. Own beliefs suppressed to up stand family beliefs, own beliefs meshed with families to keep system healthy	"..but sometimes you have to go against them (own beliefs) to make others happy"T2	2
21. Negativity indicated in verbal communications with parents, therefore affecting understanding	"Our parents didn't talk to us when we were growing up, they came from Pakistan they didn't understand their children	4
22. Emphasis on own parenting style from learning of what is was like as child them self	"Difference is that we let our children express themselves, we couldn't do that with our parents."T1	5

23. Desire to want to do things outside of the home to do something different	"It's like every day is the same and that little bit of happiness you get is like if your going to do something different"T3	3
24. Talking to family seen as main source of support	"I was lucky to have my mum who could talk to me..no one else could help me except for my family"T6	3
25. Feeling alone and isolated even in others company	"I used to feel I was alone and my feelings were alone"T1	5
26. Suicide an escape from situation	"There were times that I felt that there was no point from going on, because there was so much pressure from my dad.."T5	6
27. Mention of individual personality traits with how one copes with situations	"..it depends on what kind of person you are, if you are the type who can adapt"T3	3
28. Beliefs in a existential force that can influence life events	"It was like my destiny, and I couldn't do anything about it"T4	3
29. Not being able to cope	"I used to feel I can't cope, I used to cry a lot"T1	2
30. Not feeling normal and being afraid	"I used to feel like is something happening to me? I don't feel normal. I used to be scared of that."T1	1
31. Not being understood by others	"No one understands me"T4	2
32. Mental Health services images	"I used to feel like I had this image, I'm going to be	

	dragged away, you know in those asylums or whatever, or where they used to put people away"T1	2
33. Fear of talking about feelings to others, being labelled	"I've got depression, a mental illness, I used to be scared that if anyone found out I was going to be labelled mentally ill"T1	3
34. Media useful in promoting awareness of mental health issues	"You see like Trisha who does the show, she's been through depression. You see if people like that can say it, she's on tv..you think oh gosh it's normal to talk about it."T1	2
35. Professionals making judgements on ethnicity and gender	"He said (GP) Asian people don't suffer with depression"T1	3
36. Mental health issues taboo subject, not being able to talk about it openly in Asian culture	"Asians they see it as taboo, I mean I know what they are (mental health services) but I think Asians would not tell people if they were using these services because they would think that persons mad and something is wrong with them"T6	3
37. Not being aware of Mental Health services	"I think the problem is that there isn't information available to these (Asian) women, many women just suffer in silence"	6
38. Mention of God and religion helping in times of distress	"I started to pray a lot and thought maybe God could help me make the right decision. I felt a lot calmer and more positive"	8
39. Using work as a way of getting away from distressing situation	"What I do now is put every thing towards my work, and just don't think about other things"	3

40. Not taking own life because of responsibility to children	"..it was solely for the fact that why should my daughter be left behind..that probably stopped me more than anything"T2	2
41. Learning not to confide in others about personal things in case it got out, issues about trust	"I just couldn't tell anyone, it's just one of those things. Your just brought up not to talk about it in case it gets out"T2	4
42. Depression being okay to talk about with individuals who are not Asian	"I wanted someone who understands me and I thought to myself a White person would understand more, that is that you can have depression"T1	1
43. Only someone from the same culture being able to understand and believe what the issues are for Asian women	"it needs to be someone Asian because I think they would have more of a concept of what is believable and what sort of things do and don't happen.."T2	3

Appendix 10

List of Axial Coding
(Empirical Paper 1)

Axial Coding

Lower order categories	Higher order categories
Hidden Pain	
Feelings suppressed	**In authenticity**
Isolation of true self	
Leaving family script	
Identity Struggle	
Role Expectations	
Others not understanding me	
Feeling alone	**"Living two lives"**
Fear of others knowing	**Fear of Shame**
Unquestioned Cultural Beliefs	
Importance of shared cultural knowledge	
Success through achievement of	
being a "Good" woman	
Woman as Martyr	
Marrying a family	
Marriage Time Pressure	**Culturally determined self**
Professionals' generalisations	
of Asian women roles	
Asian culture generalisations	
of Asian women roles	**Stereotyped roles**
Cultural Expectations of Asian women	
Lack of Control	**"Me Vs the World"**
Unable to communicate with significant others	
Suicide	
Religion	**Satisfying the Extended self**
Children	
Escaping Life	**Escaping multiple selves**
Not able to Cope	
Suicide	
Influence of Existential Beliefs	

Fixed Personality Factors **Lack of control over ones life** **Suicide**	**Fatelism**
Western Mental Health **Westerners' normality** **Positive Media Roles**	**The Abnormal as Normal**
Taboo of mental health **"What are Mental Health services?"**	**Taboo of 'Madness'**

Appendix 11

Ethical considerations
(Empirical Paper 2)

Ethical Considerations

Working with potentially vulnerable participants

It is possible that the process of taking part in this study could be distressing for the participant involved. If concerns or distress is raised during the research process the researcher will respond depending on the needs of the individual. The following procedures have been designed to attempt to minimise any distress experienced during this research interview.

1) Before the interview takes place the participant will have an opportunity to ask any questions or clarify any concerns.
2) I will offer the participant time for breaks if she appears distressed or tired.
3) There will be a period of debriefing at the end of the interview, when the participant will be given the opportunity to ask any questions and given feedback about the research process.
4) At the end of the interview I will ensure that the participant is feeling generally fine to leave.
5) If necessary I will organise a second interview.

<u>Consent</u>

Written consent, to participate in the research and have the interview recorded, will be obtained

<u>Confidentiality</u>

All participant information will be kept strictly confidential. It will be coded and all identifying information will be changed to ensure anonymity.

Appendix 12

Consent Form
(Empirical Paper 2)

Programme Director
Doctorate Course in Clinical Psychology
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THE UNIVERSITY OF WARWICK

COVENTRY UNIVERSITY

PARTICIPANT CONSENT FORM

Our ref

Your ref

Title of Project: An Asian woman's experience of self-harm and attempted suicide

Date

Name of Researcher: Shazma Thabusom

Please tick box

1. **I confirm that I have understood the details of this research for the above named study and have had the opportunity to ask questions.** ☐

2. **I understand that my participation is completely voluntary and that I am free to withdraw at any time, without giving any reason. I understand that my employment and legal rights as well as my health care provision will not be affected in any way.** ☐

3. **I agree to the interview being taped.** ☐

4. **I agree to take part in the above named study.** ☐

Name of Participant	**Signature**	**Date**

Name of Researcher	**Signature**	**Date**

One copy for Participant; One copy for Researcher

Appendix 13

Semi-structured Interview Schedule
(Empirical Paper 2)

Semi-structured interview schedule

Introduction
Introducing myself – Shazma Thabusom, Trainee Clinical Psychologist, doing research on a South Asian woman experiences of attempted suicide and or self harm.
Voluntary – Can withdraw at any time – let me know if you want a break or if you do not wish to continue.
Confidentiality – Findings will be written up, but any identifying information will be changed ensuring anonymity.
Contact details – Coventry University details for Clinical Psychology will be given if contact with researcher is required post interview.
Risk assessment – Checking with participant how they feel about participating, do they have any concerns and supplying contact details for local mental health services including crisis centres.
Consent form – Reading through the consent form and allowing space for any questions before signing the form.

Interview
It is intended that the interview will follow the direction of the individual participating in the research, ideally getting the information on the experience of attempting suicide and or self harm. Therefore the following questions are to be used as a guide rather than followed rigidly.
It should also be noted that each experience will be explored either self harm, attempting suicide or other, at individual times to allow for the richness of each experience to be shared.

Opening interview questions
Tell me about yourself
How are you feeling?
Is there anything you want to start talking about with regards to this interview?

Experience of distress/self harm/ attempted suicide
When did you first think about harming yourself?
Tell me what was happening at the time?
Can you describe the times that you were distressed?
Can you tell me what happened?

Meanings of self harm/attempted suicide
How did you feel before, at the time and after self harming/attempting suicide?
Tell me what you were thinking before, at the time and after self harming/suicide?
Can you tell me what it was like?
How do you feel about it now?

Coping
What do you do now when you are distressed?
What about the situations in your life that have been distressing for you in the past?

Tell me what you think now
Tell me how you feel now

Reactions from others
Can you tell me if you had any contact with any services at that time?
What was your experience like?
Tell me what you thought at the time?
Can you tell me what your family's reaction was like at the time?
What was that experience like?
How did you feel?

What would have helped?
Can you tell me what you think would have helped you or been useful at the time, or before that time or after the experience in you life?

Is there anything else that you would like to tell me?

Debriefing
How do you feel now after talking to me about your experiences?
Do you want to ask me anything about my research?
Would you like me to send you a summary of my research findings?
Answer participant questions if they have any and then thank the participant for their involvement.

Appendix 14

Excerpt Transcription
(Empirical Paper 2)

my parents were very close to their relatives and I was the eldest child from all the families, so it was like everyone was waiting for me to reach a certain age before they could pounce on me. I was even at college doing a nursery nursing course and that was a big thing for me. A lot of the girls in my family hadn't thought about further education they all were thinking about marriage and settling down like it was the done thing. But I wanted something different for myself. I had a wicked set of mates and when all this marriage chat started I was only 17 years old. This guy at college asked me out and I just thought I'm going to do it. I hadn't been out with anyone before then, not properly. You see I didn't think I was that attractive but it didn't really bother me. I had lots of people who cared about me and that's all that seemed to matter to me. Well I went out with him for about 8 months and we had a great time. I suppose I was just being care free. It was like escaping into the world that I wanted to be in. I then did something that I had always thought about. I slept with him, I mean it was the right thing to do for me and him. You know what its like when your young and naïve. I'm a Muslim girl so the guilt I felt was terrible, but I just didn't care overall.

R Can you explain that to me?

P Well as a Muslim girl you're forbidden to have sex before marriage, its one of the biggest sins in the religion and I did it. I felt like someone was watching me saying "I know what you've done!". Then I thought the only thing I can do to make this right is to marry the same guy. I actually got pregnant, that's the thing you see. It was a nightmare. I only slept with him the once. It was like the worst thing that could have ever happened. My whole life fell apart.

R You okay?

P Ummmm (crying).

R Salma we can stop, that's fine honest.

P No I'm okay, I'd like to carry on. The thing is I've buried this for so many years. I've not really told anyone, well how could I. The thing is I had to have an abortion. I had to do all this on the quiet. When I found out my boyfriend was very supportive he said what do you want to do. I thought, at the time, like I've got a choice. I have to get rid of it. This wasn't at all the way I had planned my life. My parents would have killed me which I could have coped with but the shame on the family, my parents would have killed themselves and my sisters. My sisters wouldn't have had a life, I couldn't do that to them. I just thought I'm going to have to do this. It was so hard keeping it a secret my mood was all over the place before. I remember booking the appointment over the phone and my friends helped me. They were the only people I could talk to I didn't even go to my GP. I was too scared of someone finding out. I told my parents I had a course related day in London but I had booked myself in for the abortion. I went and did it. That day my life changed, I killed part of myself, not just the foetus. I was like a dead body, just went through it almost with no emotion because I couldn't let it out in case someone found out.

Appendix 15

List of Lower Order Categories
(Empirical Paper 2)

TEXT CUT OFF IN ORIGINAL

lf harm and attempted suicide study: Lower order categories/emergent themes and representative quotes
- 15 shared themes for self harm and attempting suicide
–27 self harm themes
– 33 attempting suicide themes

1	Fear of disclosing experience	"it's something that I haven't done in such a long time and it's difficult"L17
2	Not being able to communicate to significant others	"I couldn't talk to them (parents) …if I could I would have been able to tell them. It wouldn't have come to this…"
3	Ideal self / authentic self	"I had my romantic view of marriage"L41
4	Religion guilt	"I felt like someone was watching me, saying I know what you've done"L73
5	Alone	"I was in a world of my own suffering the hurt in silence"L106
6	Making the right choice for family	"I thought I want to do something that they would be happy with, I felt like I had already let them down"L138
7	Western lifestyle parents fear of shame	"It's all Asian parent's fear that an a daughter brings shame on the family, and the Western culture would have been blamed (talking about sex)"L134
8	Cultural self	"I was the eldest child from all my family (including extended family), so it was like they were waiting for me to reach a certain age before they could pounce on me(marriage proposals)"L53
9	Culture clash with professionals	"It was nice to talk bout there was a culture clash, there was so much I just didn't have the energy to explain about the culture, I saw this White person and thought I bet they think I'm stupid"L263
10	Lack of family support	"..i don't think anybody in my family, at that time, cared about me going to see someone so my heart wasn't in it"L270
11	Professional help = life line	"I did see someone, they were a life line. I think they helped me so much that's why I've made it through"L274
12	Need for mental health information	"the biggest thing is that they need to advertise better, like in these beauty salons, gp surgery's, or even on the bus. I think the whole culture needs education, maybe religious places, because there are men there often too"L298
13	Therapists genuineness	"This person put his heart into his work, he was genuine. If he didn't understand he would say can you explain and I want to understand, it doesn't matter about race or gender, what matters is he was willing to

		try and understand"L281
14	Children coping	"I look at my beautiful, beautiful children and I don't want them to see me hurt, so I do try"L197
15	Fear of shame	"But to be honest that's why I didn't say anything it was because the shame my family would have gone through, the family would have collapsed"L131
16	**Chaos inside**	"Cutting was my only release from the chaos inside, I was in so much pain, still am"L109
17	**Hiding pain**	"I interacted with it all like a robot. The real me was looked up inside.."L155
18	**Feeling empty**	"There was nothing in my life, I felt empty.."L148
19	**Punishing real self**	"I'd ash on my belly because that was the part of my body I really hated (abortion)"L115
20	**Harming = 'my control'**	"For me its mine, its my way of feeling like I'm in control of that side."L162
21	**Night time no pretense**	"escaping into the world that I wanted to be in"L65
22	**Secrecy**	"But I always did it so that no one else would find out, so all these stories you hear about people harming themselves for attention are bullshit
23	**Pain = connection to real self**	"the pain and scars take me back there and that's good"L159
24	**Thoughts leading to act of harm**	"I'd get scissors and just slash my arms because all these thoughts were in my head.."L111
25	**Feeling abused by suppressing ideal self**	"I suppose sometimes I used to feel fake, almost abusive like rape in a way because he (husband) had no idea what my feelings were inside"L253
26	**Self harm is coping**	" I do hurt myself, but I wouldn't even call it hurting the word I would use is it's my coping thing"L198
27	**Harming through eating**	"I mean I didn't even used to eat properly that was a way of me harming myself.."L150
28	Not being in control	"I suppose when I wasn't in control was when I tried to actually kill myself"L163
29	Giving up on ideal and cultural self	"I couldn't take it anymore, they couldn't understand me and I couldn't pretend anymore, I wanted to give up"L167

30	Saying goodbye to the ideal self	"I was crying blood tears because this wasn't the fairy tale I wanted, no where near..with each tablet I was saying goodbye to everyone"L173
31	Culture too strong	"I couldn't fight it anymore, the system was too strong; relatives and family"L176
32	Fate's role	"I remember thinking I'm going to take this as a sign, maybe I'm meant to live, so at that time I decided I was going to.L191
33	Religious perspective on surviving	"I knew that in my religion if I had ended my life I would have gone to hell so maybe for me this hell I was living on a day to day basis was better than that hell"L193

Appendix 16

Notes to contributors: Psychology of Women Section Review
(Literature Review Paper)

Psychology of Women Section Review

Aims and scope

THE PSYCHOLOGY OF WOMEN SECTION REVIEW has been established to provide a forum for discussion of issues and debates around all aspects of the psychology of women in research, teaching and professional practice. It aims to promote and support academic research and debate on issues related to the psychology of women and encourage the development of theory and practice concerning gender and other social inequalities. In particular, it also seeks to encourage contributions from individuals at all stages of their careers – including undergraduate and postgraduate students – as an appropriate forum to provide feedback on new ideas and first publications. It promotes a reviewing process where positive and constructive feedback is provided to authors.

The Psychology of Women Section Review aims to publish:

- theoretical and empirical papers;
- reviews of relevant research and books;
- special issues and features;
- observations, commentaries, interviews, short papers and original or non-traditional submissions in the 'Agora' section;
- correspondence.

It is produced by the Psychology of Women Section of the British Psychological Society, and mailed free of charge to all members of the Section. It is available on subscription to non-members of the Section. ***Libraries, organisations and individuals can subscribe at a rate of £12 per year – please send cheques payable to The Psychology of Women Section care of the Editor at the address inside the back cover.*** Issues can be purchased individually at a cost of £4 (back copies may also be available). ***For details on charges for advertising space, please contact the Editor.***

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1. All papers and submissions for the Agora section will be peer-reviewed.

2. Three hard copies of all submissions, plus a disc copy or e-mail attachment (in Word or WP for Windows or ASCII/RTF formats) should be submitted to the Editor (or Assistant Editor, where specified). A separate cover page should be provided with the title of the paper, the author's names, their institutions, addresses and telephone numbers clearly marked. *Authors are also invited to provide brief biographical information. Manuscripts should have the title clearly marked on the first page, and pages should be numbered. However, authors' names should not appear on the manuscript itself.*

3. All figures should be of reproducible standard. References should conform to the American Psychological Association (APA) system, i.e.

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4. Papers should be between 3000 and 6000 words long, and submissions for the Agora between 500 and 2000 words. An abstract of up to 150 words should be provided with papers, however, no abstract is needed for Agora submissions.

5. Book reviews and reviews of research papers will normally be commissioned by the relevant Assistant Editors. Anyone interested in reviewing books or research papers should contact the relevant Assistant Editor directly.

6. Authors should avoid the use of any sexist, racist, heterosexist or otherwise discriminatory language.

The views expressed in this publication are those of the authors, and not necessarily those of the organisations or institutions that they work for.

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Appendix 17

Notes to contributors: Journal of Community and Applied Social Psychology

(Empirical Paper 1& Empirical Paper 2)

Journal of Community & Applied Social Psychology

Subscriptions

Journal of Community & Applied Social Psychology (Print ISSN 1052-9284; Online ISSN 1099-1298 at Wiley InterScience, www.interscience.wiley.com) is published bimonthly by John Wiley & Sons, Ltd., Baffins Lane, Chichester, West Sussex, PO19 1UD, UK.

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Volume 12 2002 6 issues
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Production Information

Production Editor

Mary Mochrie M.Sc. B.Sc.
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Production Details

Printed on acid-free paper.
Typeset by Thomson Press (India) Ltd
Printed in the United Kingdom by Henry Ling Limited, at the Dorset Press, Dorchester, DT1 1HD.

Identification Statement

Journal of Community & Applied Social Psychology (Print ISSN 1052-9284; Online ISSN 1099-1298 at Wiley InterScience, www.interscience.wiley.com) is published bimonthly by John Wiley & Sons, Ltd., Baffins Lane, Chichester, West Sussex, PO19 1UD, UK. Periodicals postage paid at Rahway, NJ. Air freight and mailing in the USA by Mercury Airfreight International Ltd., 365 Blair Road, Avenel, New Jersey NJ 07001, USA.

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NOTES FOR CONTRIBUTORS

Initial manuscript submission. Submit three copies of the manuscript (including copies of tables and illustrations) to Sandra Schruijer, Faculty of Social Sciences, Tilburg University, P.O. Box 90153, 5000 Le Tilburg, The Netherlands.
Authors **must** also supply:

- an electronic copy of the final version (should normally apply, see section below);.
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Manuscript style. The language of the journal is English. All submissions including book reviews must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3 cm all round. They should not normally exceed 7,000 words in length, or equivalent in text, references and tables, and should include a word count where possible. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

- The **title page** must list the full title, a short title of up to 40 characters and names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author who is to check the proofs on this page, as the *Journal of Community & Applied Social Psychology* operates a 'blind' reviewing system.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
- Supply an **abstract** of up to 200 words for all articles, except book reviews. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
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Reference style. The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication.

Example:
Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990).
Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited.

Example:
According to Irene Taylor (1990), the personalities of Charlotte . . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary.

Example:
In a 1989 article Gould explains Darwin's most successful . .

D. Specific citations of pages or chapters follow the year.

Example:
Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears.

Example:
Sexual-selection theory often has been used to explore patterns of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate . . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al.* (meaning "and others").

Example:
Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997).

When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

Appendix 18

Notes to contributors: Feminism and Psychology
(Reflective Paper)

Feminism & Psychology
An International Journal

EDITOR:
Sue Wilkinson Loughborough University, UK

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February -
November
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Submission Manuscript Guidelines:

1. All submissions will be peer reviewed. *Papers* written in English are invited for consideration, provided they have not been published, nor are currently under consideration, elsewhere. The journal also aims to include translated pieces which have been published previously elsewhere, in languages other than English.

2. *Manuscripts* should be typewritten, double-spaced throughout, on A4, or 8.5" x 11", paper with generous margins, and not right-justified. References should be Harvard system, and in the following style:

Caplan, P.J. (1989) *Don't Blame Mother.* New York: Harper & Row.

Woolsey, L.K. and McBain, L. (1987) 'Issues of Power and Powerlessness in All-woman Groups', *Women's Studies International Forum* 10 (2): 579-88.

Griffith, A.I. and Smith, D.E. (1987) 'Constructing Cultural Knowledge: Mothering as Discourse', pp. 27-44 in J. Gaskell and A. McLaren (eds) *Women and Education.* Calgary: Detselig Press.

All figures should be of a reproducible standard. Footnotes should be kept to a minimum, and presented as End Notes. Papers should normally be between 5000 and 8000 words, but exceptionally up to 10,000 words for theoretical and empirical articles, research reviews and reports of practice; and between 500 and 2000 words for observations and commentaries. Please provide a word count. A variety of formats will be welcomed.

3. Extracts of qualitative data containing transcription notation should be prepared in the *exact* format you wish them to appear, especially as regards punctuation, spacing, underlining, etc. Each line should contain no more than 80 characters in 10pt including numbering and the peakers name.

4. Authors should avoid the use of *sexist, racist* and *heterosexist language.* Manuscripts that do not conform to these specifications will not be considered. Authors are encouraged to use clear language which avoids unnecessary jargon.

5. An *abstract* of approximately 150 words, plus 5-10 key words, should be included with each submission; but need not be supplied for observations or commentaries.

6. *Authors'* names, titles and affiliations, with complete postal and email addresses and telephone/fax numbers, should appear on a separate

cover page. Authors are invited to provide any biographical information they would wish reviewers to take into account on a separate sheet. The aim of this information is to avoid discrimination against those without standard academic backgrounds or institutional support. All submitted articles will be reviewed anonymously.

7. Submissions are welcomed for Special Features and The Spoken Word. These will normally be developed in conjunction with a member of the Editorial Group. In the first instance, suggestions should be sent to the Special Features Coordinator of the Editorial Group.

8. *Twenty-five offprints* of the article, plus a copy of the journal, will be supplied to article authors on publication.

9. *Book reviews* will normally be commissioned by the Book Review Editor although unsolicited reviews will be considered, and the journal will also review other media and relevant fiction.

10. Six copies of all manuscript submissions, including the original, should be sent to the Editorial Office: c/o Celia Kitzinger, Associate Editor F&P, Department of Sociology, University of York, Heslington, York, YO42 1QY, UK.

A copy on disk in any PC-compatible format, containing the *final* version, abstract, key words, biographical note, references and full contact details, will be required before publication, but should *not* be included with the initial submission. Further information may be sought from any member of the *Editorial Group*.

ii. *Copyright*: Before publication authors are requested to assign copyright to SAGE Publications, subject to retaining their right to reuse the material in other publications written or edited by themselves and due to be published at least one year after initial publication in teh journal.

Information for book reviewers:

Much feminist theory, research and practice in relation to psychology is published in book form rather than as journal articles. Therefore book reviews play a key role in the journal *Feminism & Psychology* and we appreciate reviewers who are willing to spend time to write reviews for the journal. Our aim is to publish book review sections which are informative and stimulate further discussion and debate. We encourage reviewers to discuss the particular reviewed book(s) in the context of other contemporary feminist thinking within and beyond academia. Further, we are keen to receive reviews which take a constructively critical approach (criticism which is directed at the content of the book and not at the author(s)).

Feminism & Psychology publishes two kinds of book review.

1) A short review of between 500 and 1,000 words draws attention to the book, not simply by describing the book's contents but also by providing some discussion of the aim(s) of the book and an evaluation of the extent to which these aims are met.

2) A longer review of between 1,000-2,000 words. F&P encourages reviews which move beyond a summary of the contents to provide a critical evaluation of the arguments and approach taken to the subject matter by the author(s). A book review that takes up the author's theoretical, conceptual, practical, political and/or methodological arguments and develops a debate around these issues can become a piece that is worth reading in its own right. In this respect a review can do more than simply act as a substitute for reading the original text.

We also encourage another possibility - a review essay, of up to 4,000 - 5,000 words. In a review essay, several books in a topic area (on average 3) are reviewed together in order to explore the topic and the

contributions of the texts. The arguments in a review essay will therefore be more wide-ranging.

How to become a book reviewer for F&P

If you are interested in reviewing for *Feminism & Psychology*, then please get in touch with the reviews editor (address and e-mail below). The reviews editor receives review copies from publishers and if she knows your interests/research area she can contact you when she has a relevant text for review. Alternatively she can request review copies that would be suitable to your area of expertise or you may already have a book which you would like to review for F&P.

We provide more specific review criteria for the preparation of a review. The length of time available to do the review is negotiable. Ideally you would take 2 or 3 months - longer for review essays. We have to have copy ready at least 6 months before publishing, so it takes some time to get into print.

We hope to publish all reviews / review essays we commission or agree. Occasionally reviews may need to be returned for some revision, or the reviews editor may make some minor amendments. The editor has the final say.

Angie Burns,

Book Reviews Editor

Feminism & Psychology

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College Road, Stoke on Trent, ST4 2DE, U

Email: a.m.burns@staffs.ac.uk